Digitized by the Internet Archive
in 2016

https://archive.org/details/journalofmedical81unse

January 1984

Journal of the Medical Society of New Jersey



Autopsies: Newark City Hospital
W.D. Sharpe, M.D.

Area Health Education Center Program
M.A. Landay, D.D.S., et al.

Acute Radiation Pneumonitis
S. Silberstein, M.D., et al.

Table of Contents
Page 4

The Library
Acquisitions Division
Univ. of Calif., San Francisco
San Francisco, Calif. 94143

LIBRARY
U.C. SAN FRANCISCO
JAN 27 1984

Send this coupon for no-obligation information of the savings under the Medical Society of New Jersey Endorsed Insurance Plans

Check this list against your coverages . . . .

- ☐ $5000 Monthly Guaranteed Convertible Accident and Health
- ☐ $10,000 Monthly Practice Overhead Expense
- ☐ $1,250,000 Term Life Insurance
- ☐ $500 Deductible COMPREHENSIVE MILLION-DOLLAR MAJOR MEDICAL PLAN—No other coverage needed—Issuable to Age 69
- ☐ $15,000 Deductible MILLION-DOLLAR UMBRELLA MAJOR MEDICAL PLAN for holders of Blue Cross and other Major Medical Plans—Issuable to Age 69
- ☐ $100-a-day Hospital Income Policy
- ☐ $200,000 High Limit Accident Plan
- ☐ Keogh and Corporate Plan NOW! $15,000 KEOGH

E. & W. Blanksteen Agency, Inc.

E. & W. Blanksteen
75 Montgomery St.,
Jersey City, N.J. 07302
(201) 333-4340
or (800) 742-2849

Name: _____

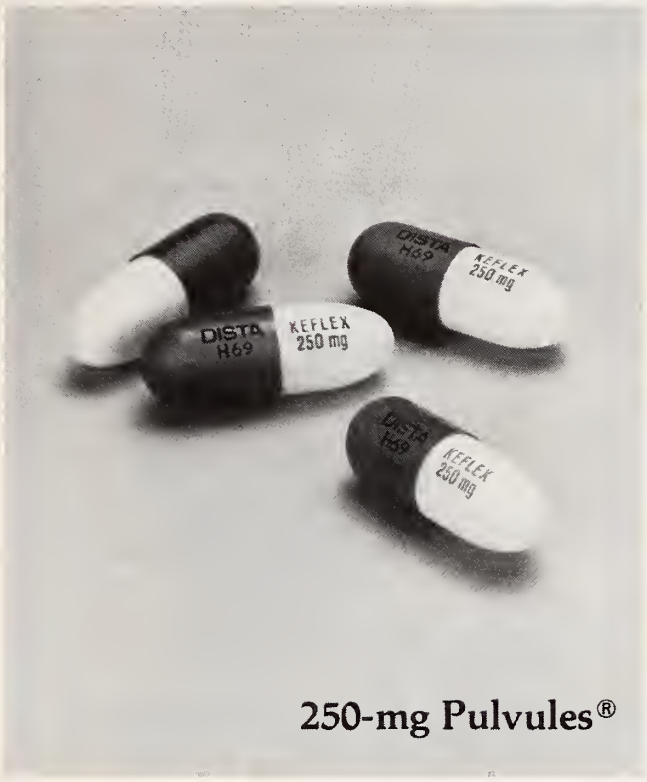
Address: _____

_____

Tel. No. _____

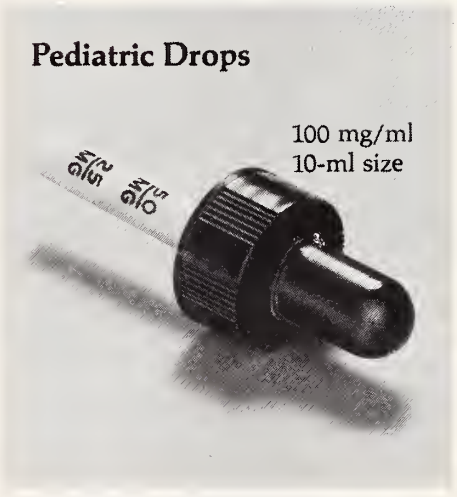
Best Time To Call _____

easy to take



250-mg Pulvules®





Keflex®
cephalexin

Additional information available
to the profession on request.

DISTA
000823

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

Officers and Trustees

PRESIDENT
Alexander D. Kovacs, M.D. (Union) ..... Scotch Plains
PRESIDENT-ELECT
Frank Y. Watson, M.D. (Essex) ..... Glen Ridge
FIRST VICE PRESIDENT
Ralph J. Fioretti, M.D. (Bergen) ..... Rochelle Park
SECOND VICE PRESIDENT
Edward A. Schauer, M.D. (Monmouth) ..... Farmingdale
IMMEDIATE PAST PRESIDENT
Howard D. Slobodien, M.D. (Middlesex) ..... Metuchen
SECRETARY
Arthur Bernstein, M.D. (Essex) ..... South Orange
TREASURER
Paul J. Hirsch, M.D. (Somerset) ..... Bridgewater

Trustees

Douglas M. Costabile, M.D., *Chairman* (1984) (Union) .. Murray Hill
Frank Campo, M.D. (1984) (Mercer) ..... Trenton
Harry M. Carnes, M.D. (1985) (Camden) ..... Audubon
Joel S. Cherashore, M.D. (1986) (Essex) ..... Nutley
John J. Crosby, Jr., M.D. (1984) ..... Jersey City
Palma E. Formica, M.D. (1984) (Middlesex) ..... New Brunswick
Harry W. Fullerton, Jr., M.D. (1985) (Salem) ..... Carney's Point
Frank Gingerelli, M.D. (1986) (Bergen) ..... Hackensack
William Greifinger, M.D. (1984) (Essex) ..... Belleville
John P. Kengeter, M.D. (1984) (Ocean) ..... Toms River
Edwin W. Messey, M.D. (1985) (Burlington) ..... Willingboro
Myles C. Morrison, Jr., M.D. (1985) (Morris) ..... Morristown
John J. Pastore, M.D. (1986) (Cumberland) ..... Vineland
Michael R. Ramundo, M.D. (1984) (Passaic) ..... Clifton

Councilors

FIRST DISTRICT
(Essex, Morris, Union, and Warren Counties)
Edward M. Coe, M.D. (1984) ..... Cranford
SECOND DISTRICT
(Bergen, Hudson, Passaic, and Sussex Counties)
Robert A. Weinstein, M.D. (1986) ..... Newton
THIRD DISTRICT
(Hunterdon, Mercer, Middlesex, and Somerset Counties)
Albert F. Moriconi, M.D. (1985) ..... Trenton
FOURTH DISTRICT
(Burlington, Camden, Monmouth, and Ocean Counties)
Frederick W. Durham, M.D. (1984) ..... Haddonfield
FIFTH DISTRICT
(Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties)
Paul H. Steel, M.D. (1986) ..... Atlantic City

AMA Delegates

William J. D'Elia, M.D., *Chairman* (1985) ..... Spring Lake
Alfred A. Alessi, M.D. (1984) ..... Hackensack
Frederick W. Durham, M.D. (1984) ..... Haddonfield
Palma E. Formica, M.D. (1984) ..... New Brunswick
Karl T. Franzoni, M.D. (1984) ..... Trenton
John S. Madara, M.D. (1984) ..... Salem
Henry J. Mineur, M.D. (1984) ..... Cranford
Myles C. Morrison, Jr., M.D. (1985) ..... Morristown
Howard D. Slobodien, M.D. (1985) ..... Metuchen

AMA Trustee

James S. Todd, M.D. (Ridgewood) ..... Bergen

January 1984

Publication Committee

Paul J. Hirsch, M.D., *Chairman*
Dirck L. Brendlinger, M.D.
Frederick B. Cohen, M.D.
A. Olusegun Fayemi, M.D.
Robert M. MacMillan, M.D.
Leon G. Smith, M.D.
La Verne Fioretti

Editor

Arthur Krosnick, M.D.

Managing Editor

Geraldine R. Hutner

Assistant Managing Editor

Dorothy J. Griffith

Advertising Manager

E. Elizabeth Cookson

Executive Director

Vincent A. Maressa

Executive Director Emeritus

Richard I. Nevin

Editorial Board

Jerome Abrams, M.D. (Obstet/Gynecol)
Harold Arlen, M.D. (Otolaryngol)
Alfonse Cinotti, M.D. (Ophthalmol)
Stuart D. Cook, M.D. (Neurol)
Robert Dodelson, M.D. (Nephrol)
Wm. A. Dwyer, Jr., M.D. (Surg)
Norman H. Ertel, M.D. (Int Med/Endocrinol)
Arthur Goldfarb, M.D. (Allerg/Clin Immunol)
Christine E. Haycock, M.D. (Sports Med)
Monroe S. Karetzky, M.D. (Pulmon Med)
Avrum L. Katcher, M.D. (Pediatr)
Joel D. Levinson, M.D. (Gastroenterol)
Henry R. Liss, M.D. (Neurosurg)
Geobel A. Marin, M.D. (Int Med/Gastroenterol)
Robby Meijer, M.D. (Plas Surg)
Christopher A. Papa, M.D. (Dermatol)
Victor Parsonnet, M.D. (Vasc Surg)
Norman Riegel, M.D. (Book Review)
Edwin L. Rothfield, M.D. (Cardiol)
Benjamin F. Rush, Jr., M.D. (Surg)
Morris H. Saffron, M.D. (Med His)
Mark M. Singer, M.D. (Int Med/Endocrinol)
Sheldon D. Solomon, M.D. (Rheum)
Lloyd N. Spindell, M.D. (Radiol)
A. Arthur Sugerman, M.D. (Psychiat)
Edwin S. Wilson, M.D. (Radiol)
Louis S. Zeiger, M.D. (Nucl Med)
Robert B. Zufall, M.D. (Urol)

The Journal of the Medical Society of New Jersey (ISSN-0025-7524) is published monthly (since 1904) except semimonthly in July (13 issues), under direction of the Committee on Publication, by the Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648. Printed in East Stroudsburg, PA, by the Hughes Printing Co. Whole number of issues 958. Member's subscription ($10) is included in Society dues. Rates for nonmembers, $20; outside USA add $7.50 for postage. Single copies, $2. Address communications to *The Journal* MSNJ, 2 Princess Road, Lawrenceville, NJ 08648, (609) 896-1766. Second-class postage paid at Trenton, NJ, and additional entry office.

Copyright 1984 by the Medical Society of New Jersey.

2 SAAB

good reasons for buying or leasing your BMW or SAAB from JMK





Our People

Our Service

- Specialized and individual service departments
- Computerized body and repair facilities
- Over $300,000 parts inventory
- Concerned, caring, conscientious sales, service, parts people

From tires to tail lights . . . From radios to radiators . . . If you own your BMW or SAAB for 20 years . . . you'll never have to bring it to anyone else.

Specialist in Sales/European Delivery Program/ Leasing/Financing

Call for appointment for FREE FACTORY DEMONSTRATION!

JMK
AUTO SALES

391 RT. 22 (East) Springfield, N.J. • 379-7744

January 1984

Journal of the Medical Society of New Jersey

America's First Medical Society

CONTENTS

7 **MEMBERSHIP NEWSLETTER**

13 **PROFESSIONAL LIABILITY COMMENTARY**

EDITORIAL

17 William Carlos Williams, M.D.—A Postscript

21 **HOSPITAL GOVERNING BOARDS**

26 **JEMPAC REPORT**

SPECIAL ARTICLE

31 AMA Principles of Medical Ethics

ARTICLE

37 The Area Health Education Center Program
M.A. Landay, D.D.S., B.L. Cohen, D.O., R.C. Reynolds, M.D., Camden

CASE REPORTS

43 Infantile Embryonal Carcinoma in Children
P.S. Affuso, M.D., and A.O. Fayemi, M.D., Teaneck

45 Peroral Esophageal Endoprosthesis for the Management of Incurable Esophageal Carcinoma
M.N. Kalkay, M.D., B. Pancer, M.D., A. Derman, M.D., Holmdel

49 Acute Radiation Pneumonitis
S. Silberstein, M.D., D. Malcolm, M.D., E.V. Braun, M.D., A.O. Fayemi, M.D., Teaneck

MEDICAL HISTORY

53 Autopsies at Newark City Hospital, 1908 to 1911
W.D. Sharpe, M.D., South Orange

63 **PEDIATRIC BRIEFS**

IMPAIRED PHYSICIANS PROGRAM

65 *D.I. Canavan, M.D., Lawrenceville*

DOCTORS' NOTEBOOK

68 Trustees' Minutes: November 20, 1983

69 President's Column, *Alexander D. Kovacs, M.D.*

70 UMDNJ Notes, *Stanley S. Bergen, Jr., M.D.*

71 MSNJ Auxiliary, *Mrs. Gale Wayman*

71 AMNJ Report, *Paul J. Hirsch, M.D.*

71 New Members

72 Physicians Seeking Location in New Jersey

74 Housing Application

75 Medical Philately, *Joseph A. Kler, M.D.*

77 CME Calendar

81 Letters to the Editor

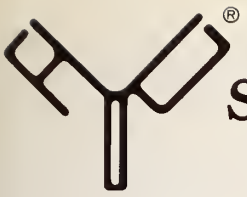
82 Obituaries

83 Book Reviews

85 Information for Authors



On The Cover: Our cover photograph shows a working Dr. Harrison S. Martland, a pathologist at Newark City Hospital from 1908 to 1952. The medical history of autopsies performed at Newark City Hospital from 1908 to 1911 uncovers a wealth of material; read the full story on page 53. Cover photograph: UMDNJ, Archives/George F. Smith Library, 100 Bergen Street, Newark, NJ 07103.



AID SERVICE CORPORATION

Specializing in allergy and immunology testing.

One of our greatest contributions to medicine is giving you more time to practice and an opportunity to provide more services for your patients.

MODERN

Over the years you may have heard a lot of controversy about the modified RAST test versus the old scratch and stick test methods of allergy diagnosis. What you haven't heard much about is how to modernize and upgrade your practice so that you can get more time for the things you really want to do. AID can help you with that.

SAFE and ACCURATE

Because we offer a safe, efficient and accurate method of providing the patient with fast, precise, definitive allergy diagnosis and treatment capability, we can save you the irreplaceable time you'd lose by continuing to perform skin tests. If you are referring patients for these tests now, we can offer to you a system that allows you to confirm an allergy diagnosis by merely drawing a blood sample. Treatment extracts based on serum levels of specific IgE are available on your request.

COMPREHENSIVE

Our comprehensive services include a broad range of in-vitro diagnostic tests performed on human serum for the diagnosis of allergic and immune deficiency diseases. In fact, we can perform specific tests for almost 200 different types of allergies on a blood sample. These results can confirm the presence of IgE mediated (type I) allergy and can form the basis for rational immunotherapy based upon the quantitative levels of IgE to a specific allergen.

CONVENIENT

In addition, our method increases the patient's acceptance, while reducing costs, and increases your office productivity by reducing congestion. It's also ideal for infants and children who are afraid of skin tests, patients with skin conditions that contraindicate skin tests and those who can not discontinue medication that would interfere with skin tests.

EFFICIENT

If you'd like to spend more time successfully treating patients, instead of wasting time and energy on costly and time-consuming methods, call your AID expert today.



Allergy Immunology Diagnostic Service Corp.
P.O. Box F
Maywood, New Jersey 07607
(201) 836-2844
or call toll-free:
(800) 631-1379

AID SERVICE CORPORATION uses quality reagents from VENTREX LABS, INC.

It's about time you had a real professional assist you in attaining your personal, practice and retirement investment goals.

Dr. S. Randy Sarantos is that professional.



A doctor with over 20 years of financial experience, who is now a full-time Registered Investment Advisor and financial planner counseling health care professionals, Dr. Sarantos understands the special problems you face in developing your personal estate plan, managing your practice economic goals, planning for your retirement, and investing your pension assets.

Dr. Sarantos is a member of the International Association of Financial Planners and is licensed through Investment, Management & Research, Inc., member National Association of Securities Dealers and Security Investors Protection Corporation and an affiliate of Raymond, James & Associates, Inc., member New York Stock Exchange, in the securities, tax shelter, commodities and insurance investment areas.

For a confidential consultation with Dr. Sarantos, please call or return the coupon below today. He is ready to answer the many diverse financial questions that probably only *another* health sciences professional can effectively answer.

Dr. Sarantos:
Please contact me regarding the following area of interest:

☐ Developing a financial plan
☐ Investment management
☐ Tax shelter planning
☐ Insurance review
☐ Retirement plan review
☐ Practice management review

Name _____

Address _____

City/State/Zip _____

Office Phone ____/_____ Home Phone ____/_____

Call 800-223-0164
or 201-539-4000 (NJ only)

SARANTOS & LANSING
FINANCIAL SERVICES, INC.
240 Cedar Knolls Rd., Cedar Knolls, NJ 07927

MEMBERSHIP NEWSLETTER

MSNJ

THE MEDICAL SOCIETY OF NEW JERSEY VOLUME 6

MEDICAID FACTS

Physicians frequently are criticized for Medicaid abuse and the high cost of health care. An analysis of Medicaid payments by service category in New Jersey in 1973 and 1983 indicates physicians are not the cause of the problem but like the patients have become victims of the system.

Physician reimbursement has dropped from 13.5 percent of the service budget in 1973 to 7 percent of the service budget in 1983.

Physician reimbursement constitutes total payment to physicians for all types of service, i.e. diagnostic, therapeutic, medical, surgical, outpatient, and inpatient.

In fiscal year 1983, hospital outpatient services were reimbursed in the amount of $63 million. This exceeded total physician reimbursement by $6.3 million.

Medicaid's response to this situation is the Personal Physician Plan or "gatekeeper" concept that centers on the primary care physician as a "case manager" which pays the physician on a per capita basis and places him at risk for services ordered.

MSNJ maintains the "gatekeeper" is not the answer. Fair and reasonable fees to physicians for services rendered in their offices is the only real answer. Every other approach is simply an effort to avoid coming to grip with the basic issue.

TABLE

Medicaid Payments

	Fiscal Year 1973 (millions)	Fiscal Year 1983 (millions)
Hospitals	86.9	297.1
Nursing homes	76.3	278.4
Drugs	18.3	61.6
Other	30.7	99.4
Physicians	33.1	56.7
Total	$245,253,840	$793,180,750

NEW ECFMG EXAM

ECFMG plans to administer the new foreign medical graduate examination in the medical sciences (FMGEMS) each January and July beginning in July 1984. The examination will consist of a one-day test in the basic medical sciences and a one-day test in the clinical sciences, both derived from the pool of questions in the basic and clinical sciences maintained by the National Board of Medical Examiners. The ECFMG English test will be given with each administration of FMGEMS.

The final ECFMG examination in the present format will be given for the last time in January 1984, and the final Visa Qualifying Examination was administered in September 1983.

Individuals attending medical schools listed in the current edition of the *World Directory of Medical Schools* may take the basic sciences component of FMGEMS at the end of two years at the school, and they may take the clinical sciences component when they are within 12 months of completing the formal didactic requirements of the medical school.

MEDICARE ASSIGNMENT— FEE FREEZE

The American Medical Association strongly urged Congress to reject provisions requiring physicians to accept Medicare assignment and to roll back Medicare physicians' fees for hospital inpatient services. The Association pointed out that the House Ways and Means Committee already had rejected these two proposals. The Association also strongly opposed proposals to require hospitals to obtain agreements from all members of its medical staff to accept assignments for all Medicare inpatient services. (Letter to all members of the House of Representatives, October 24, 1983)

MUTUAL PROTECTION ASSOCIATIONS, S. 1745

The AMA supports **S. 1745,** a bill that would provide tax-exempt status to physicians' and surgeons' mutual protection and indemnity associations providing malpractice insurance. The bill also provides that initial payments made by a physician or surgeon to

such entities would be tax deductible as a business expense. The bill represents a reasonable step towards providing equality of tax treatment for this form of providing essential professional liability coverage. (Letter to Senator Robert Dole, Chairman, Senate Finance Committee, October 25, 1983)

PATIENT RECORDS

The following is a letter sent to the State Board of Medical Examiners on September 14, 1983, by the Legal Counsel to MSNJ along with the complete text of the Request for Declaratory Ruling:

Dear Doctor Riggs:

In reading through the June 8, 1983, minutes of the State Board of Medical Examiners, I have noted that the State Board listed a detailed format of record keeping in a disciplinary action against a chiropractor.

A review of the New Jersey Administrative Code and the New Jersey Statutes Annotated reveals that the format for medical records required by the Board has not been established by statute or regulation. There is, therefore, uncertainty in the medical community as to what the Board of Medical Examiners deems to be adequate.

I am, therefore, submitting the enclosed request for a declaratory ruling.

(signed) Vincent A. Maressa
Legal Counsel

Medical Society of New Jersey
Two Princess Road
Lawrenceville, New Jersey 08648
(609) 896-1766

Department of Law & Public Safety
Division of Consumer Affairs
State Board of Medical Examiners
Docket No.

In the Matter of the Request of the
Medical Society of New Jersey
for a Declaratory Ruling.

Request for
Declaratory Ruling

The Medical Society of New Jersey, with offices located at Two Princess Road, Lawrenceville, New Jersey, by way of a request for a declaratory ruling pursuant to *N.J.S.A. 52:14B-8,* says:

1. On or about June 8, 1983, the State Board of Medical Examiners found that a chiropractor, Howard I. Cantor, D.C., was guilty of repeated acts of negligence and malpractice when it found that Doctor Cantor failed to record in his patient records a complete history, description of the examination rendered, physical findings, a diagnosis on those physical findings, a descripton of the treatment rendered during each patient visit, and a notation of any progress made by the patient from one visit to another. The Board found that failure to make such patient records was a deviation from accepted standards of chiropractic practice.

2. The Medical Society of New Jersey is a professional society which represents over 9,200 fully licensed New Jersey physicians and surgeons.

3. The Medical Society denies the existence of any statute or regulation which declares that a physician or surgeon in the state of New Jersey is required to keep records in the same fashion as those required by the Board of Medical Examiners with respect to chiropractors.

4. No action is pending in any court involving the matters herein in dispute.

Wherefore, plaintiff requests a declaratory ruling whereby the State Board of Medical Examiners shall set forth that a physician in the state of New Jersey is not required to maintain patient records in the same fashion as chiropractors.

Dated: September 14, 1983
Medical Society of New Jersey
By: Vincent A. Maressa
Legal Counsel

— — — — — — — — — —

The following response dated November 14, 1983, has been received from the State Board of Medical Examiners and is printed at their request and for your information and guidance:

Dear Mr. Maressa:

On behalf of the Medical Society of New Jersey, you have submitted a Request for Declaratory Ruling regarding the keeping of medical records by physicians. You assert that there is no "statute or regulation which declares that a physician or surgeon in the state of New Jersey is required to keep records in the same fashion as those required by the Board of Medical Examiners with respect to chiropractors" and you ask the Board to agree with that statement, as if that statement permanently settled the implied matters raised in your letter. Your cover letter of September 14, 1983, states that the "format for medical records required by the Board has not been established by statute or regulation."

We make several observations at the outset:

1) Your request sets forth certain elements of a patient's record which purport to be those held by the Board in the case of *in re Cantor, D.C.* to be required of a chiropractor. Your list, however, not only fails to include all the elements set forth in the Board's Order in that case, but also changes the wording in a manner which materially alters the sense of the Order. For example, you omitted reference to x-ray findings—which can be a very important aspect of chiropractic practice, and required inclusion of that data in the diagnosis and treatment plan. This is sig-

nificant because the fundamental thrust of the Board Order in that case was to stress the theory of scientific method as applied to a professional practice—where pertinent—and a rationale in patient management.

2) The "format" of a record, to which you refer, relates more to form and organization than to substantive content, and therefore is not particularly relevant to the subject at hand, except where substance is absent.

3) The scope of practice of a licensed chiropractor is vastly different from that of a licensed physician or surgeon. The records of a Doctor of Chiropractic must therefore inevitably contain certain minimum data which will not necessarily be part of the record of a Doctor of Medicine or a Doctor of Osteopathic Medicine, and vice versa.

Thus, it is clear that the question you pose actually answers itself—and yet is not the significant question at all. We shall assume that the real question you pose is this: Is there a mandatory minimum content to a physician's patient record and if so, what is it and by what standard is it imposed?

It is clear that neither the Legislature nor the Medical Board has deemed it necessary thus far to adopt a law or rule specifying the answer to your question. This is because the answer is found in the standards of accepted practice in the profession, and as carried out in the various specialties. Modern medical schools teach the practice of medicine and surgery based upon the scientific method. That method presumes—certainly on the part of persons licensed in this state and, we believe, generally across the country—that the physician has studied and acquired a significant fund of knowledge of anatomy, biology, physiology, neurology, chemistry, physics, pharmacology, psychology, etc. The profession of medicine expects that the plenary-licensed physician will bring the study of these sciences to bear upon the total condition of each patient presenting with a complaint. It is the doctor's task to receive and make a record of the subjective complaints that brought the patient to seek treatment; to consider what physical and psychological examination seems indicated, both minimally and particularly, in light of the problem presented, based upon the doctor's training and experience. The doctor must then effectuate the appropriate examination and record the findings. If the doctor believes x-rays are warranted, in spite of their recognized risk, in order to make a proper diagnosis, then a proper performance of the x-ray procedure is expected, as is a report of the findings. Similarly, if subjective and clinical findings make laboratory studies advisable, it is expected that they will be properly performed and evaluated, and the results integrated into the doctor's diagnosis. Where surgery is involved, consultation may, on occasion, be appropriate, and should be reflected in the record.

If, in the treatment plan, medication is deemed necessary, it is expected that the physician will make careful determination of the indications and contraindications, and will appropriately inform the patient of the treatment goals, risks, and cautions. When a Controlled Dangerous Drug is the drug being prescribed, extra care must be taken. Because of the abuse potential of these drugs, the physician is expected to be particular in recording the drug prescribed, its quantity, dosage unit and frequency, and the date the prescription is issued. The physician must comply also with all pertinent rules of the Department of Health and of the Board of Medical Examiners and federal government respecting utilization of the drugs themselves and record-keeping requirements. Clearly, certain administrative procedures have been ordered by rule because of the inherent dangers of these drugs—which have been magnified by careless practices on the part of some physicians. Other requirements are simply codifications of the good general practices dictated by common sense.

We need not address the necessity of patient informed consent to the examination to be conducted, and the treatment to be given. These issues have been amply dealt with in medical training, in common sense, and in widely publicized cases indicating the consequences of failure to assure adequate communication and agreement between physician and patient. Where significant treatment risks are involved, good practice would seem to require that patient consent be included in the record.

In short, the content of the physician's patient record is established by standards of accepted medical practice pertaining both to general practice and to a specialty, as appropriate. Physicians recognize that medical practice always involves a reception, examination, and evaluation of subjective complaints, objective findings, analysis, and treatment plan—whether it be in the area of general practice or psychiatry. A current rule of the Medical Board, *N.J.A.C. 13:35-6.5,* requires that a patient record be prepared and maintained for seven years from date of last entry. Sections (b) and (c) of that rule make clear that a patient record is expected to include objective data as well as a nonobjective data portion.

The making of a written record is of assistance to the busy physician—who may not remember on a subsequent visit observations or findings which seemed significant—or unexplained—on a prior visit. It is of assistance when reviewed retrospectively, to perceive a general pattern of behavior which may have diagnostic or prognostic significance. It is important for the substantial portion of our population which is transient, for the patient who is moving and needs to carry to the next health care professional a proper and complete medical history, to avoid costly trial and error in treatment. Finally, we must recognize that a written record may be significant in the course of inquiry or even litigation, where the appropriateness of the treatment has been called into question. A doctor best can protect the integrity of the medical treatment process by having noted the significant elements of the

treatment. These concerns do not require the writing of a book on the occasion of each patient visit; but they do warrant the recordation of basic data and all such other data as medical training and experience teach us are significant in aiding us to bring to bear our special training in order to provide good medical care to our patients.

In summary, standards of accepted practice establish the proper content of the physician's medical record on each patient. Where the state or federal government, or administrative agencies, have found additional or more explicit requirements to be necessary, they have been promulgated by law or rule, and it is the obligation of each licensee to remain current with respect to law and rules applicable to that licensed profession. Professional societies can certainly aid their memberships in this regard, by calling particular notice to new rule proposals and adoptions and to legislation. It is for that reason that the Board of Medical Examiners has regularly invited representatives of the Medical Society of New Jersey to attend the public meetings of the Medical Board, in hope that the representatives will carry back to the membership news of importance in the development of the profession.

We trust that this letter answers the direct and indirect questions in your cover letter and Request for Declaratory Ruling. As your questions were submitted on behalf of the membership of your Society, we anticipate that you will make the Board's views available to the entire membership.

Yours truly,
(signed) Edwin H. Albano, M.D.
President
NJ State Board of Medical Examiners

MARKETING STRATEGIES FOR PRIVATE PRACTICE

The traditional ways of practicing medicine in the United States have been undergoing a transition for several years.

The manner in which health service is being offered with its multiple modalities is confusing and somewhat threatening even to people who have been practicing for many years.

The new doctors coming into practice are confronted with various delivery systems of medical care that they will be forced to contend with. The established older physicians need to be made aware of the changes that have taken place and what effect it will have on their future.

As a service to its membership, MSNJ is willing to cosponsor a program on coping with these changes in conjunction with the AMA Department of Practice Management.

The subject matter of the program would cover medical marketing, how to meet patients' needs, and planning for changes coming from business, government, and the insurance industry. The planning for changes in health care delivery systems and changes in hospital/physician relationships will be discussed.

The professional relations necessary to maximize patient satisfaction will be included and cover dealing with patients on a one-on-one basis.

Pricing of services with a look at your options and how to communicate credit and fee policies clearly will be discussed.

The mobility of the American people resulting in population shifts brings about changes in medical practicing opportunities. Deciding where you will locate or relocate is important to your professional success and this will be covered.

Practice viability is vitally important. Community involvement, community service, and proper advertising will be part of the program.

The workshop will allow ample time for group questions and answers.

The cost of this all-day session will be $100 to cover the expenses of the speakers and food. This is a tax-deductible expense. If 20 members or more write MSNJ indicating their interest in the workshop, we will make it available at the Executive Offices.

MEDIA TECHNIQUES SEMINAR

The Council on Public Relations and MSNJ are aware of the necessity of enlightening our membership with the proper procedures for dealing with the various media. This especially is true for those physicians who aspire to leadership positions in the medical profession.

The Medical Society of New Jersey will be offering its second Media Techniques Seminar at the Executive Offices, Two Princess Road, Lawrenceville, on Wednesday, March 21, 1984, from 9 A.M. to 4:00 P.M. Luncheon will be served. The registration will be limited to the first 50 applicants. There will be a fee of $30 to cover expenses and lunch. This is a tax-deductible expense and a worthwhile experience.

This seminar is an excellent opportunity to learn how to handle media interviews and gain exposure to the various public relations techniques. Outstanding media personalities will be participating in this seminar. There will be ample opportunity for questions and answers and role play sessions.

HEALTH CARE FOR THE UNEMPLOYED AND NEEDY

The Society's Council on Medical Services feels that substantial unemployment, along with reductions in Medicaid and disability programs, continue to make it difficult for increasing numbers of people to obtain necessary health care. Because of the need further to address the problem of health care for the unemployed and needy, the AMA has requested the distribution of a letter designed to be utilized by physicians, with

modifications to fit their office letter format and style, for distribution to their patients (Figure). The purpose is to make patients aware of the physician's desire to respond to the economic hardship of his unemployed and needy patients through provision of necessary medical care on a free or reduced fee basis or through creation of other appropriate financial arrangements. Physicians also are urged to continue to discuss with local hospitals ways to allow for necessary hospitalization for those who have lost their health insurance because of unemployment or changes in eligibility or coverage for Medicaid or disability programs.

Dear Patient:

At a time when substantial unemployment, along with reductions in Medicaid and disability programs, continue to make it difficult for increasing numbers of people to obtain necessary health care, I want to assure my patients that such circumstances will not be a barrier to my provision of necessary medical services.

I believe it is important that you continue to receive the medical care you need. Provision of the best medical care possible, as always, is my primary goal in serving my patients.

If you would have difficulty in paying my bills because of unemployment and a loss of health insurance or due to a cutback in Medicaid or disability program, please let me or my staff know. We can make arrangements to provide for necessary care on a free or fee-reduced basis, or make other financial arrangements.

Most importantly, do not hesitate to seek my services because you are having financial problems beyond your control. Please let me or my office staff know if you would like to discuss my policy on this further. Sincerely,

FINI

No talent or record of achievement is necessary to criticize another.

AN ACT OF LOVE

Their own **DENIAL** that a respected colleague could be **IMPAIRED** and/or the "conspiracy of silence" that makes them unwilling to speak out allows the illness of our impaired colleagues to progress, sometimes to a fatal outcome.

"Blowing the whistle" on a suffering colleague is indeed an **ACT OF LOVE!**

Call Us **EARLY**
We can help **CONFIDENTIALLY**
IMPAIRED PHYSICIANS PROGRAM
(609) 896-1766
Hot Line . . . (609) 896-1884

"A MIDLANTIC CREDIT LINE CAN PUT $100,000 RIGHT AT YOUR FINGERTIPS."

"Investments. Auctions. College. Business expansion.

"Will you have ready capital when golden opportunities knock? The Hungry Bankers say 'Yes.'

"We give you a choice of credit lines that put you in touch with a whole world of financial freedom.

"Chec-King, for instance, adds the convenience of a line of credit to your Midlantic checking or NOW account. Whenever you need money, write a check —up to the limit of your credit line.

"Or how about our Capital Line℠ account? It gives you a personal line of credit based on the equity you've built up in your home. Anywhere from $10,000 to $100,000.

"Any time a great opportunity comes your way, simply write one of your Capital Line checks. As often as you like. For as little as $500. Or as much as $100,000.

"Applying is easy, too. Just stop by any Midlantic office. Our brief application could be the last of its kind you'll ever have to fill out.

"Let the Hungry Bankers put up to $100,000 of financial leverage right at your fingertips.

"Then, when you need it, you've got it."

FOOD FOR THOUGH FROM THE HUNGRY BANKERS

MIDLANTI



Bob Van Buren, Chairman, Midlantic Banks Inc.

Mem
Equal Opportuni

Court Decisions

The Appellate Division of the Superior Court of New Jersey held that a lower court had erred in ordering the removal of a nasogastric feeding tube from an 84-year-old nursing home patient (*In Re Conroy,* 190 N.J. Super. 453, App. Div. 1983).

The patient, Claire Conroy, suffered from severe organic brain syndrome, decubitus ulcers, diabetes, and arteriosclerosis. Her only living relative, a nephew, petitioned the court to authorize the removal of the tube after Ms. Conroy's treating physician refused to do so.

The lower court ordered the tube removed but its decision was appealed immediately and the tube was not removed. The patient died two weeks after the lower court's order was issued.

The Appellate Division of the Superior Court held that the lower court erred in ordering the removal of the tube. It said that the removal of the tube would cause death by dehydration and starvation and would violate a basic principle of medical ethnics, "to do no harm." The court said that the decision to remove life support should be limited to those patients who are incurable and terminally ill and who are irreversibly comatose or vegetative. It said, "to allow a physician or family member to disconnect life-sustaining treatment to a person solely because that person's lack of intellectual capacity precludes her from enjoying a meaningful quality of life would establish a dangerous precedent that logically could be extended far beyond the facts of the case before us." The Supreme Court of New Jersey had agreed to hear the Conroy case. As of this writing, the state's highest court has not yet issued its opinion.

CAN THE OBSTETRICIAN DOCUMENT REASONS FOR DECISIONS?

A practical tip from a clinician-academician could help obstetricians guard against possible "bad baby" claims. His suggestion is to make sure fetal monitoring done during labor and delivery, whether by auscultation or electronically, is recorded.

"Nurses generally can monitor a patient in labor as well as the equipment can," said Clark Miller Hinkley, M.D., chief, department of obstetrics, Baylor College of Medicine. "But if it isn't recorded, (as far as the courts are concerned) you didn't do it. That's one of the major problems in (baby) cases today. The plaintiff contends that the physician didn't adequately monitor labor."

The malpractice threat has stimulated many physicians to provide better records, Dr. Miller said, but added, "I see a lot of them who are not properly documenting what happened. Doctors take shortcuts in paperwork, because there's so much of it, and I don't know how we can get around it."

Should an obstetrician store all the tapes when electronic fetal monitoring is used? A busy obstetrician could fill a room with the miles of tape generated, Dr. Miller pointed out. Here's his solution:

"I put an interpretation of the monitoring slip in the chart right after delivery and then I throw the tape away, just as the doctor who takes an EKG usually does."

Dr. Miller was not making a case for electronic fetal monitoring, except with high-risk patients or when there are ominous indications during labor that call for internal fetal monitoring. Referring to a Denver study by Albert Haverkamp, M.D., Dr. Miller said there are times when electronic monitoring can lead to performance of unnecessary cesarean sections.

It was the conclusion of Haverkamp that the monitoring pattern does affect the method of delivery "despite the fact that these data indicate very little predictive value in the pattern." Dr. Haverkamp, with James R. Murphy, M.D., and other associates at Denver General Hospital, studied the relation of electronic fetal monitoring patterns to infant outcome measures and stated that considerable work needs to be done before they can be used reliably as an indicator of infant distress. In addition, Haverkamp concluded, "Studies need to be conducted which separate chronic, morbid fetal conditions which lead to ominous patterns from acute fetal distress during labor." *(Medical Liability Monitor,* Vol. 8, No. 7, July 29, 1983)

FLORIDA APPEALS COURT UPHOLDS $12 MILLION AWARD BUT CUTS ATTORNEY'S BIG FEE

A Florida district appeals court has upheld a $12.47 million jury award—the largest in the state's history—to a comatose woman who suffered brain damage in a Lauderdale Lakes hospital, but has reduced an award of $4.4 million in legal fees to the plaintiff's attorney in the case. The West Palm Beach Appeals Court reduced Sheldon J. Schlesinger's award under a two-year-old state law that calls for the loser in a medical malpractice suit to pay "reasonable attorney's fees" to the winner to $1.5 million.

---

*This item from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse who are, respectively, Director of the Department and Director of Special Projects.

Schlesinger still could collect a contingency fee from the family of Susan Von Stetina of between 30 and 50 percent—or between $4 million and $6 million—in addition to the court-awarded $1.5 million. Schlesinger, who has obtained seven jury verdicts in excess of $1 million, reportedly charges a standard 40 percent contingency fee and as much as 50 percent if the case is appealed.

Susan Von Stetina, 30, suffered irreversible brain damage and now is in a permanent coma when a respirator at Florida Medical Center failed in the night and the malfunction was not discovered until morning. She had undergone surgery following an auto crash.

In March 1982, a Broward County Circuit Court jury awarded Ms. Von Stetina $7.5 million for lifetime medical costs and care, and $5 million for pain and suffering. Appellate Judge Gavin K. Letts, likened her state to "the tortures of the damned," and said she was entitled to the award.

Florida Medical Center and the state's Patient Compensation Fund say they will appeal the award to the Florida Supreme Court. Florida sources say the fund has half of its assets pledged in this case and somewhere between $125 million and $175 million pending in unpaid claims. The PCF stopped writing protection for physicians and hospitals in late June. *(Medical Liability Monitor,* Vol. 8, No. 8, August 29, 1983)

DID YOU KNOW . . .

The trend toward million-plus jury awards is accelerating, claims Jury Verdict Research Inc. which tracked a total of 536 personal injury suits with high payouts? Significantly, one-third were made in the past three years.

St. Paul Companies report that their insured doctors are averaging 4.8 claims per 100, up from 2.9 per physician in 1975?

WHERE MALPRACTICE SUITS ARE MOST LIKELY TO OCCUR

More than 25 percent of all malpractice claims against physicians stem from surgery-related incidents, according to a study of claims incurred by the nation's largest medical liability insurer, St. Paul Fire and Marine Insurance Co. (Table). The highest awards for damages, however, are made on claims for birth-related problems resulting from improper treatment. *(Medical Economics,* September 19, 1983)

TABLE

Top 15 Malpractice Claims Against Physicians (1982)

Nature of Claim	Number of Claims
Postoperative complications	541
Improper birth-related treatment	245
Failure to diagnose fracture or dislocation	207
Inadvertent act during surgery	191
Inappropriate surgical procedure	168
Failure to diagnose cancer	144
Improper treatment of fracture or dislocation	120
Failure to diagnose infection	109
Improper treatment of infection	109
Improper treatment involving drug side effects	108
Failure to diagnose pregnancy-related problems	103
Lack of treatment supervision	97
Insufficient therapy treatment	86
Postoperative death	79
Improper treatment during examination	71

DOCTORS REFUSE TO BUY INSURANCE; MICHIGAN HOSPITAL REVOKES PRIVILEGES

Exercising a right which the courts around the nation increasingly have upheld, a Michigan hospital recently revoked staff privileges of three physicians who refused to buy malpractice insurance on grounds that it was too costly.

Early in June, Sinai Hospital, Detroit, sent warning letters to about 25 of the nearly 800 physicians on staff advising them that they could not continue to practice in the institution without proof of malpractice insurance. When the cutoff date passed in late June, 3 physicians immediately were dropped. Fourteen of a possible 16 physicians filed suit in Wayne County Circuit Court, but Judge Roland Olzark refused their request for a temporary restraining order to block the dismissals.

Originally, the hospital stipulated that each doctor must carry $1/$1 million in coverage, but the amount was reduced to $200,000/$600,000 after complaints by physician staff members. *(Medical Liabiility Monitor,* Vol. 8, No. 7, July 29, 1983)

When It Comes To HOME HEALTH CARE HoMed Provides The PASSPORT HOME...



HOMED has more than 25 Years of Professional Experience in providing Home Health Care Products & Services...from

- CONVALESCENT EQUIPMENT & REPAIRS
- OXYGEN & RESPIRATORY THERAPY
- PARENTERAL/ENTERAL NUTRITIONAL THERAPY
- INFANTILE APNEA MONITORING
- BARRIER-FREE HOME MODIFICATION
- SPECIALIZED HEALTH PROFESSIONALS REGISTRY

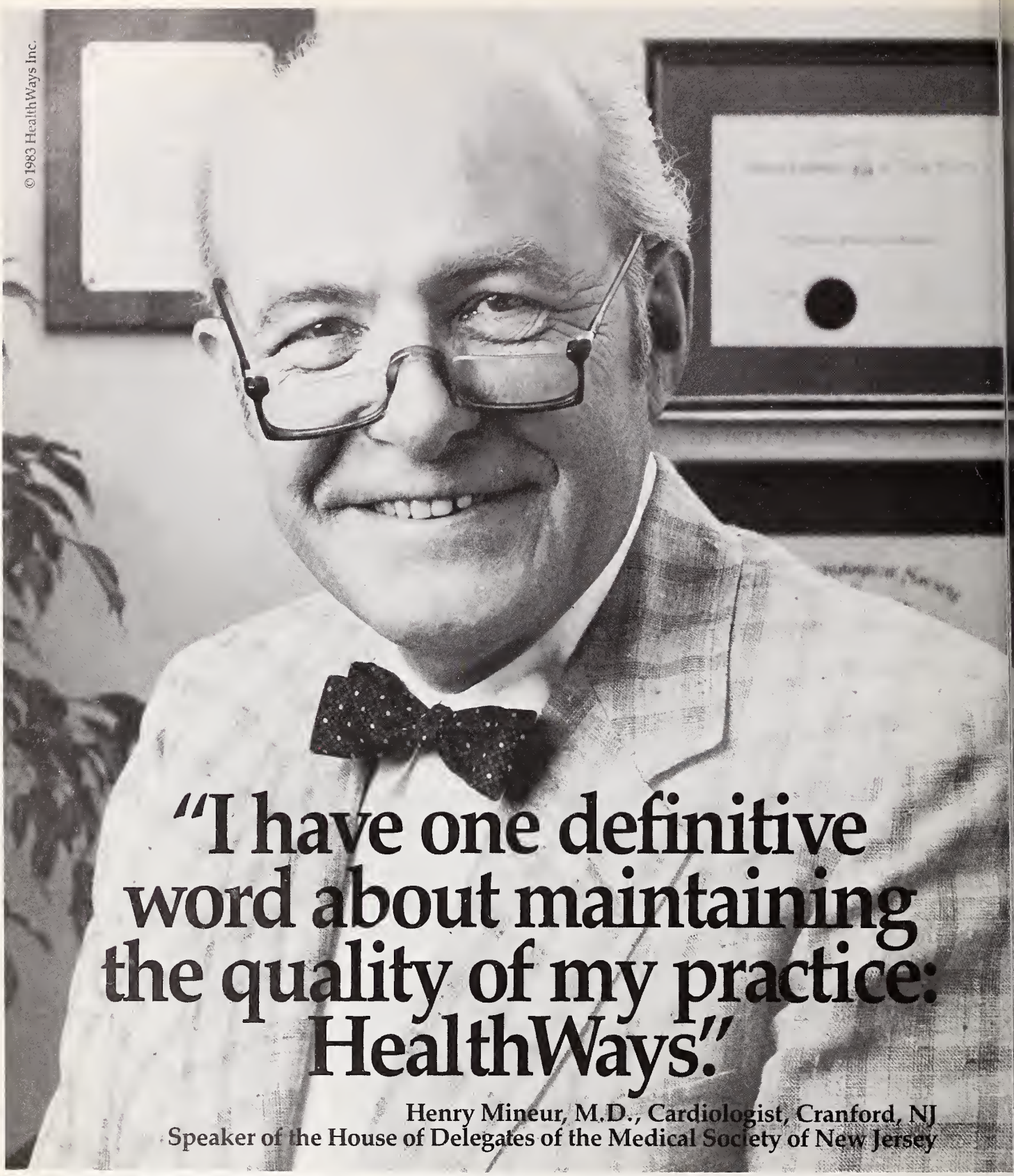
...to assisting Physicians and their Patients in Securing Specialized Care and Services.

HOMED™...the Home Health Care Company

Serving the Greater Metropolitan Area

CALL TOLL FREE...NORTHERN NEW JERSEY (800) 452-9777-SOUTHERN NEW JERSEY (800) 392-6936
OUT OF STATE - Call Collect (201) 227-1800

© 1983 HealthWays Inc.



"I have one definitive word about maintaining the quality of my practice: HealthWays."

Henry Mineur, M.D., Cardiologist, Cranford, NJ
Speaker of the House of Delegates of the Medical Society of New Jersey

"Sadly, as the cost of medical care increases and the scope of many health insurance programs decreases, my patients wind up in a terrible squeeze. I found a very satisfactory solution. I became a participating physician in HealthWays.

With HealthWays, I can practice the kind of medicine that will truly benefit my patients without worrying about their financial positions because of the HealthWays unique physician reimbursement policy. That's a significant plus.

In addition, the administrative and financial structure of HealthWays is fighting the astonishing escalation of costs by covering procedures easily done on an out-patient basis rather than in the hospital. That makes a lot of sense. So does their policy of covering routine check-ups. And since the bills go directly to HealthWays, the specter of unpaid bills is eliminated."

HealthWays can be most valuable to your practice too. For more information, call Jon Marsicano, M.D., Vice President, Medical Affairs, at 201-636-6200 or 609-394-1995.

HealthWays
THE WAY TO BETTER HEALTH CARE.

William Carlos Williams, M.D.—A Postscript

On Sunday, September 11, 1983, a group of physicians, artists, composers, professors, authors, and their spouses and friends, gathered in Princeton to "celebrate a man, a physician, and a poet, on the 100th anniversary of his birth." Poems were read. Anecdotes of personal encounters with Williams were recited.



Arthur Krosnick, M.D.

The highlight was the comment of William Eric Williams, M.D., who lives and practices pediatrics at 9 Ridge Road, Rutherford, the home and office of his father, William Carlos Williams, M.D. (1883-1963). A.K.

" *'The Use of Force'* carries in it probably all of pediatrics in a nutshell. "Williams's short stories . . . say as much about pediatrics, which is my work, as anything I've ever seen written." Avrum L. Katcher, M.D.



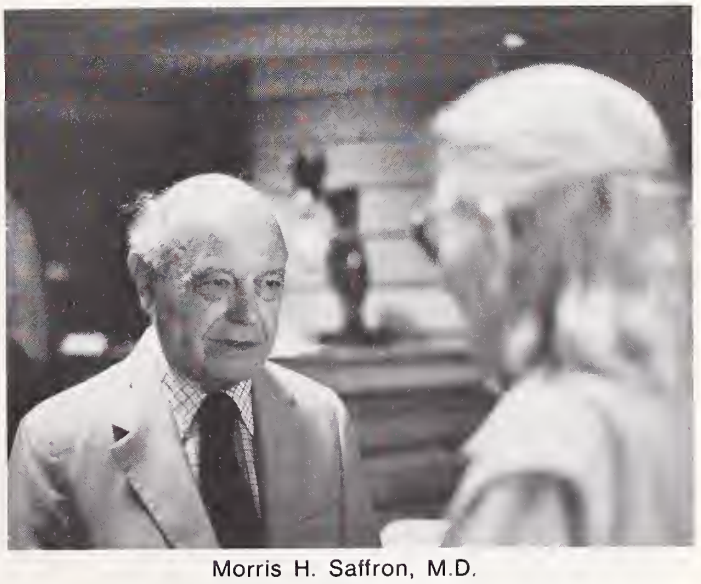
Avrum L. Katcher, M.D.

"When I first read 'The Sparrow' (a poem dedicated by William Carlos Williams (to my father) many years ago), I really was moved by it. The final image of the poem is the one I tried to make a painting of. I made some drawings and studies; then, finally, I started working on a painting of this dead sparrow lying in the road. I just couldn't make it work, so I just put it away. About a year later, I was looking for something on which to paint, and I had completely forgotten what was on this panel. It was just a white panel to me. I put it up on the easel, and I started making a self-portrait. In the process, all of a sudden, to my surprise, this bird came up over my head. I called this self-portrait, The Sparrow." Henry Niese



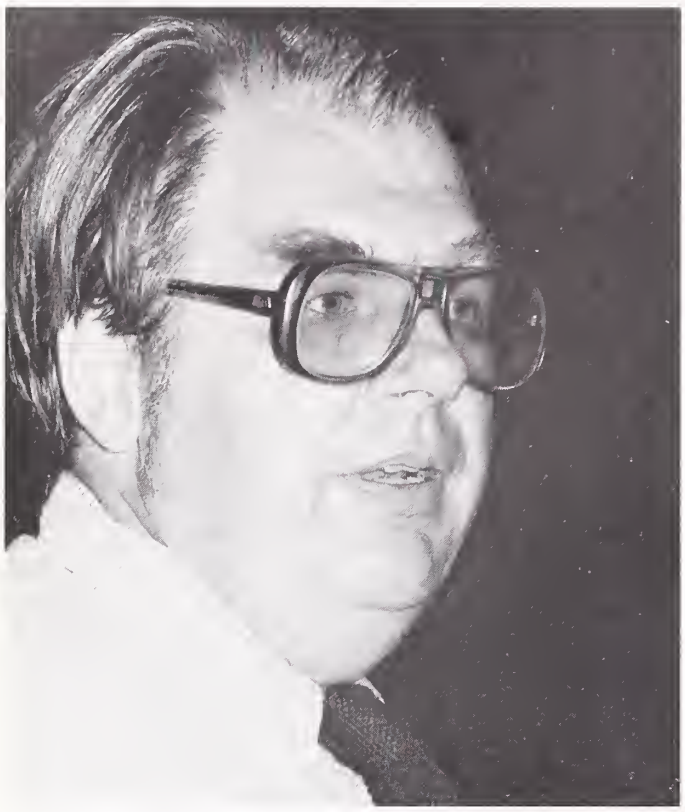
Bill Smith and Henry Niese

"Dr. Williams sent most of his patients to the Passaic General Hospital, but occasionally he did come to St. Mary's Hospital. One day, I was introduced to the great man. I had just finished reading *Paterson,* and I told this august individual that I'd just finished reading this wonderful poem. He was a taciturn person, and he didn't react very strongly, but he did turn to me and say, 'My God, you deserve a medal of honor for reading that junk!' He was surprised that any young person would wade through that great epic."
Morris H. Saffron, M.D.



Morris H. Saffron, M.D.

"As I became acquainted with him, there were many admirable things about Williams. The one I would choose would be his persistence. When he started as a poet in the 1910s and 1920s, it was a period of great experimentation. People were doing all sorts of strange and in some cases, like Williams, really very wonderful things, all kinds of new



James Guimond, Ph.D.

forms. He also was persistent in the way he could shift his creativity, not only between medicine and literature, but also within literature itself. When he started having trouble—like most poets—with dry periods, he would start writing prose. For example, he produced the wonderful short stories which he started writing in the 1930s. At first he did this because the poetry was coming very slowly."

James Guimond, Ph.D.

"'The Widow's Lament in the Springtime' was written in 1922. I came across it basically not only as a result of having read a great deal of William Carlos Williams, but also because of that famous book by Yvor Winters called *Primitivism and Decadence,* in which he analyzed this poem. When I met William Carlos Williams, at the Brandeis Creative Arts Festival (very likely in 1957), there were poetry readings of Williams's writing. I was involved in the musical aspects of it. We sat and talked quite a bit about this analysis of Winters, which Dr. Williams may have remembered. After I set to music 'The Widow's Lament' it was performed first here in Princeton by Bethany Beardsley, a soprano, at the time of a memorial service for the first chairman of the Princeton Music Department, Roy Dickinson Welch."

Milton Babbitt



Milton Babbitt

"I think your *Journal* is very successful—the issue is terrific—the people did a great job. It's been quite a year for me—with this climax now of the issue of *The Journal.* The



Dr. and Mrs. William Eric Williams and Henry Niese

following is part of the foreword to a new biography (in press) by Leo Baldwin:

"His life's work was poetry, his avocation—medicine.

"Poetry became his addiction, his habit, the gyroscope that kept him on an even keel when the going got rough. He found poetry everywhere, no need to search, just keep the receptors uncluttered and let it come to you. Get it down while it's hot, no garble, no distortion, nothing artificial. I'm sure he was familiar with the old orthopedic adage, 'splint it where they lie.' To the physician this means to immobilize the fracture before the patient or some well-meaning Samaritan damages the injured part further. He would practice this in his own poetry. When an old woman takes a plum from a wrinkled paper bag and relishes its flavor and juiciness, say so. When a cat climbs over a jam closet, putting its paws precisely, rhythmically, into some clay pots, say so. If some bawdy dancers with big cans, hips, and breasts shake the joint as they go round, and round, and round, say so. And he did! He was a capable and respected physician, he was an accurate and honest reporter in his poetry. The trained observer physician complemented the vibrant imagist in the poet. Either occupation for most men would be a full-time job. Fortunately, he had an inexhaustible flow of energy that made it possible to do both jobs well—the doctor nurtured the poet through his privileged admission into the lives of his patients, the poet returned into the physician the distillate of his observations, making the doctor a more humane and altruistic minister to the sick. But, it was a lonely existence, I suspect. There was little time or energy left once the poet and the physician had been sated. He was exploring new frontiers—a frontier always is scantily populated. He was overthrowing or attempting to overthrow a tradition. He took the bit in his teeth, kicked over the traces, and galloped for the horizon." William E. Williams, M.D.

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android®/5 mg. Buccal/10 mg. Oral/25 mg. Oral
Methyltestosterone U.S.P. Tablets

ANDROID®/F
Fluoxymesterone U.S.P. Tablets, 10 mg.





Outpatient Pulmonary Services

- Complete and limited pulmonary function tests
- Arterial blood gas studies
- Exercise physiology evaluations (cardiopulmonary stress tests)
- Pulmonary rehabilitation programs

Services include typed report returned to referring physician within 48 hours, or sooner upon request. Same-day telephone report, if requested.

Conveniently located across from Morristown Memorial Hospital. Staffed by board-certified physician and technician specialists.

Brochure, *A Physician's Introduction to The Breathing Center*, available on request.

The Breathing Center

Testing, Diagnosis & Conditioning

101 Madison Ave Morristown, NJ 07960 • 201 539-5330

Doctors: Write your own prescription to cure insurance pains . . .

℞ Prescription

Name MSNJ Member

MSNJ Group Blue Cross/Blue Shield Major Medical and Dental Insurance

that provides:

- **Flexible plans**
- **Comprehensive benefits**
- **Low, competitive rates**
- **Centralized Administration**

Designed and Administered by
DONALD F. SMITH & ASSOCIATES

℞ Prescription

Name _____

Address _____

Phone _____

Please send more information on the MSNJ

- ☐ Blue Cross/Blue Shield Program
- ☐ Major Medical Program
- ☐ Group Dental Program

Return to:
Donald F. Smith & Associates
One Airport Place, Route 206 North
P.O. Box 2197,
Princeton, New Jersey 08540
(609) 924-8700, (201) 622-6046

HOSPITAL GOVERNING BOARDS*

AMA House of Delegates' Actions

Hospital governing board members include a minority of physicians, yet the decisions made closely embrace the professional lives of the hospital's medical staff. Since the American Medical Association is one of the organized voices of American physicians, it behooves the hospital governing board to be cognizant of AMA policies, just as the hospital governing board must study the platforms of the American Hospital Association and the myriad official health-regulating agencies that impact on the health industry.

At its 1983 Annual Meeting, the House of Delegates of the AMA debated many resolutions, but adopted as policy six which pertain to issues of interest to hospital medical staffs and thus to governing boards as well.

Physician Credentialing: "Resolved, that the American Medical Association recommends that hospital medical staffs adopt bylaws which enable such medical staffs to retain the prerogative and responsibility, as granted by the hospital governing body, for credentialing all physicians and other licensees who apply for clinical privileges, including those who seek to enter into contractual arrangements with hospitals."

In this column (October 1983), Dr. James E. George pointed out the pitfalls of credentialing and the potential legal ramifications of the process as it affects the hospital and its governing board. It seems quite logical that the essence of credential review is that of "peer review." Who is better qualified to evaluate physicians and other health professionals who provide clinical services?

Open Nomination and Election for Medical Staff Officers: "Resolved, that the American Medical Association supports the right and responsibility of hospital medical staffs to have an open and democratic nomination and election process for medical staff officers."

Although the hospital governing body retains unto itself the final judgment as to who shall be officers of the medical staff through an approval process, it clearly would be inimical for the board to reject the elected officers without overwhelming evidence of misfeasance in the elective process. Representation of the governing board may and should observe the elective process, but the likelihood of shenanigans is small.

Confidentiality in Medical Staff Peer Review: "Resolved, that the American Medical Association encourages medical staff peer review committees when evaluating the professional practices of fully licensed physicians to consider excluding nonphysicians."

Confidentiality, through computer intrusion, "right to know" concepts, and the urgency to record every word lest a potential medical-legal confrontation arise, has been shattered irreparably. However, common sense dictates that the complexities of medical-surgical practice are beyond the ken of the nonphysician observer in a peer review climate to process unfamiliar data and come out with a balanced evaluation. "Trials" by the news media based on inadequate information, ineptitude, and bias, have virtually made a shambles of the American jury system. In the interest of fair play, medical staff peer review committees may serve their hospital and its clients better by meeting in executive session when sensitive matters which may be misinterpreted are discussed.

Bylaws, Rules, and Regulations: No Incorporation by Reference: "Resolved, that the American Medical Association encourages medical staffs to develop their own bylaws, rules, and regulations and not to incorporate other documents by reference."

The hospital governing body has its own bylaws and the hospital medical staff has a constitution, rules, and regulations. It is obvious that conflicts between the staff's canons and those of the Board of Directors can be resolved by the latter by fiat. It equally is obvious that the staff can avoid conflicts by accepting the governing body's prescripts as its own in a mindless fashion. Neither of these choices is desirable in these days of fluidity in the science, technology, and economics of medicine and health services. The hospital medical staff, being aware of the consequences of new concepts, new developments, and new relationships, must be free to govern itself within those constraints that are essential. Rules and regulations, as they pertain to patient care, must be subject to revision and fine tuning. The physician must retain this prerogative and responsibility.

Incorporation of Medical Staffs: "Resolved, that the

*The material for this column is coedited by Arthur Krosnick, M.D., Editor, *The Journal,* MSNJ; Vincent A. Maressa, J.D., Executive Director, MSNJ; and James E. George, M.D., J.D., Director of the Department of Professional Liability.

American Medical Association investigates all aspects of the incorporation of medical staffs and report back to the House of Delegates at the 1984 Annual Meeting."

Why should a hospital medical staff consider incorporation? Why, indeed, should the modern hospital be a corporation and why should the individual practitioner be incorporated? The reasons for each of these facts of life in America are manifold and complex. They are related to tax laws, security for the future, and protection of the individual. A hospital medical staff tends to appear like an amorphous, faceless, ever-changing group of professionals whose individual contributions to the hospital and its patients are limited by time, health, and other factors. The AMA reference committee "believed that the merit of this concept should be studied before the AMA developed bylaws or assisted medical staffs in efforts to incorporate." Obviously, medical staffs are free to consider incorporation without the AMA intervening; therefore, hospital governing boards should be aware of this consideration.

Legal Counsel for Hospital Medical Staffs: "Resolved, that the American Medical Association encourages medical staffs to consult with their own attorneys or those of their county medical society, state medical society, and/or AMA in securing knowledgeable legal counselors as appropriate."

Most physicians, individually and in groups, are not lawyers, yet many of their professional activities, their decisions, and their problems as a hospital staff may have legal implications. Balanced judgment would suggest that the medical staff should seek its own legal counsel rather than to utilize the hospital corporation's legal advisors. In fact, it would appear that the latter may have a conflict of interest and should step aside and encourage the medical staff to consult its own attorney.

Hospital governing boards and medical staffs are powerful groups made up of educated, intelligent, and successful men and women. Shared ideas should help strengthen mutual respect and cooperation.

A.K.

Motrin®
ibuprofen, Upjohn
600 mg Tablets



More convenient for your patients.

Upjohn

984 The Upjohn Company

The Upjohn Company • Kalamazoo, Michigan 49001 USA

J-4044 January 1984

This Publication is available in Microform.



University Microfilms International

Please send additional information
for _____
Name _____
Institution _____
Street _____
City _____
State _____ Zip _____

300 North Zeeb Road
Dept. P R
Ann Arbor, Mi 48106

WHY AMA?

Residents and medical students now have a strong voice in organized medicine. Through the Resident Physician Section and the Medical Student Section, these two groups participate in the policy making process of the AMA and communicate their concerns. Developing future leadership in organized medicine: it's one more good reason why you should be a part of the AMA.

To Join,
Contact your county or state medical society or write: Division of Membership, AMA, 535 North Dearborn Street, Chicago, Illinois 60610 or call collect, (312) 751-6196.

AMA AMERICAN MEDICAL ASSOCIATION

References:
1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCAROIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use oi PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCAROIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCAROIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request. © 1982, Pfizer Inc.

Pfizer LABORATORIES DIVISION
PFIZER INC

"I can do things that I couldn't do for 3 yrs. including joining the human race again."



Quotes from an unsolicited letter received by Pfizer from an angina patient.
While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

© 1983, Pfizer Inc.

"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

*Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA *brief summary on adjoining pa*

JEMPAC REPORT

Political Action and Political Activity

The Medical Society of New Jersey can look forward to the 1984-1985 session of the legislature with heightened interest and optimism, thanks in large measure to our best effort of supporting pro-physician candidates in the November legislative elections (Table).

Physician response was generous—even enthusiastic—in the campaign fund raising activities of MSNJ's political action committees, JEMPAC and MedAc. Reflecting the tireless efforts of JEMPAC Chairman, William E. Ryan, M.D., (Mercer County), the committees together contributed $66,300 to incumbent legislators and challengers who are supportive of medicine. In the 120 legislative races, MSNJ supported 100 candidates of whom 87 won and 13 were defeated.

Democrats retained control of both the Senate (23-17) and the Assembly (44-36). The new Senate includes 20 Democrats and 15 Republicans who received MSNJ support. In the new

TABLE

New Jersey Legislature 1984-1985

District	Senate	Assembly
1	James R. Hurley*	Joseph W. Chinnici—Guy F. Muziani
2	William L. Gormley*	Dolores G. Cooper*—John Edward Kline*
3	Raymond J. Zane*	Martin A. Herman—Thomas A. Pankok*
4	Daniel J. Dalton*	Anthony S. Marsella*—Dennis L. Riley*
5	Walter Rand*	Francis J. Gorman*—Wayne R. Bryant*
6	Lee B. Laskin*	Thomas J. Shusted*—John A. Rocco*
7	Catherine A. Costa*	Barbara Faith Kalik—Thomas P. Foy*
8	H. James Saxton*	Robert J. Meyer*—C. William Haines*
9	Leonard T. Connors, Jr.*	John T. Hendrickson, Jr.*—Jorge A. Rod*
10	John F. Russo*	John Paul Doyle*—Marlene Lynch Ford
11	Frank Pallone, Jr.	Anthony "Doc" Villane*—Joseph A. Palaia*
12	S. Thomas Gagliano*	Marie Sheehan Muhler*—John O. Bennett*
13	Richard Van Wagner*	William E. Flynn*—Jacqueline Walker
14	Francis J. McManimon*	Joseph L. Bocchini*—Joseph D. Patero*
15	Gerald R. Stockman*	John S. Watson*—Gerard S. Naples*
16	John S. Ewing*	Walter J. Kavanaugh*—John (Jack) Penn*
17	John A. Lynch*	David C. Schwartz—Angela L. Perun
18	Peter P. Garibaldi*	Frank M. Pelly*—Thomas H. Paterniti
19	Laurence S. Weiss*	Alan J. Karcher*—George J. Otlowski
20	Raymond J. Lesniak*	Thomas J. Deverin*—Thomas W. Long*
21	C. Louis Bassano*	Chuck Hardwick*—Edward K. Gill*
22	Donald T. DiFrancesco	Bob Franks*—Maureen Ogden*
23	Walter E. Foran*	Richard A. Zimmer—Karl Weidel*
24	Wayne Dumont, Jr.*	Robert E. Littell*—Garabed Haytaian
25	John H. Dorsey*	Arthur Albohn*—Rodney P. Frelinghuysen*
26	Leanna Brown	Dean A. Gallo*—Ralph A. Loveys*
27	Richard J. Codey*	Harry A. McEnroe—Mildred Barry Garvin
28	John P. Caufield*	Michael F. Adubato*—Jimmy Zangari
29	Wynona M. Lipman*	Willie B. Brown*—Eugene H. Thompson*
30	Carmen A. Orechio*	A.J. "Buddy" Fortunato*—Stephen Adubato, Jr.
31	Edward T. O'Connor, Jr.*	Joseph Doria, Jr.*—Joseph Charles, Jr.*
32	Thomas F. Cowan*	Paul Cuprowski*—Anthony Vanieri
33	Christopher J. Jackman*	Robert A. Ranieri—Nicholas J. LaRocca
34	Joseph L. Bubba*	Newton E. Miller*—Gerald Zecker
35	Frank X. Graves, Jr.*	John Girgenti—Vincent Ozzie Pellecchia*
36	Joseph Hirkala*	Robert Hollenbeck—Richard Visotcky
37	Matthew Feldman	Byron Baer—D. Bennett Mazur
38	Paul Contillo	Louis Kosco*—William P. Schuber
39	Gerald Cardinale*	John Markert*—John E. Rooney
40	Garrett W. Hagedorn*	Walter M.D. Kern, Jr.—Nicholas R. Felice*

*=MSNJ Support

Assembly, we supported 24 Democrats and 28 Republicans.

These results tremendously overshadow any of MSNJ's past efforts. For example, JEMPAC was able to contribute only $18,650 in the 1981 legislative and gubernatorial races; JEMPAC had 317 members that year. In 1983, JEMPAC's 610 members contributed $27,700 to the legislative races and MedAc—the fund raising mechanism created specifically for the legislative elections—contributed $38,600.

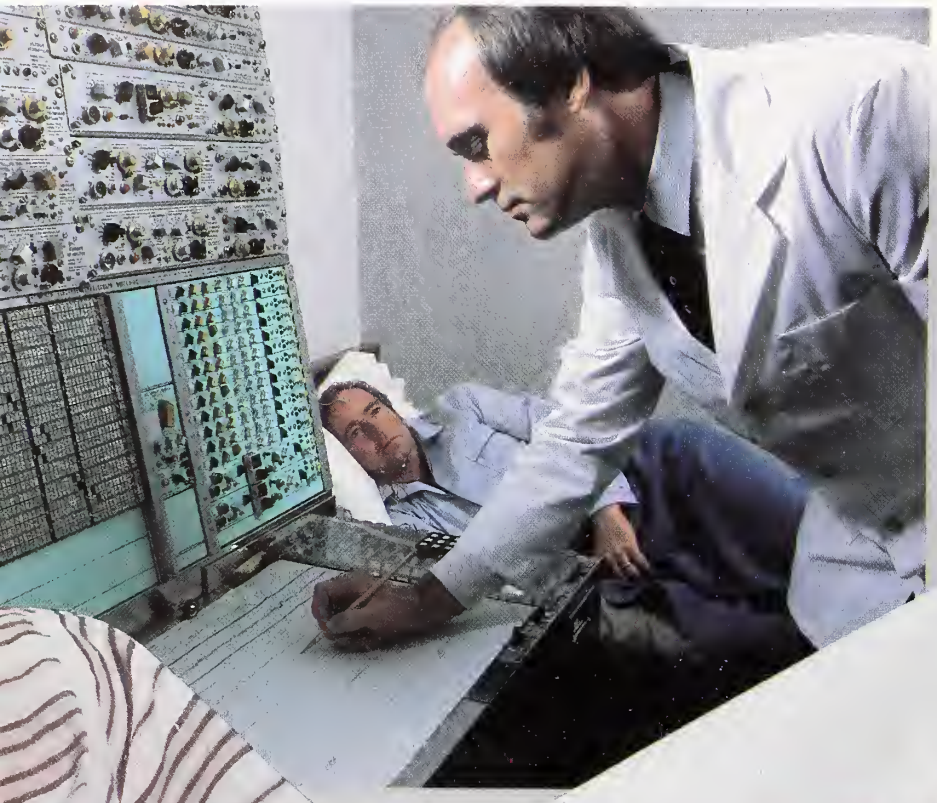
Political action of this magnitude comes not a moment too soon. Last year was MSNJ's most politically active year in the legislature. We successfully fought the seemingly endless battle against the combined efforts of administration and the automobile insurance lobby to create a statutory medical fee schedule for physician services for auto accident victims. At the same time, we battled back an extremely well-organized attempt of the Optometric Association to pass a law permitting optometrists to prescribe drugs. Numerous other skirmishes flared up throughout the year: a move by the physical therapists to establish themselves as freestanding practitioners, a variety of incursions by nonmedical groups to gain health insurance reimbursement for their services.

From our lobbying activity we certainly learned who our friends were in the legislature, and it was time for MSNJ to show its appreciation for their help by supporting their campaigns with contributions of $500, $750, and more. One example stands out: Senator James Bornheimer (D-East Brunswick), chairman of the Labor, Industry, and Professions Committee where many of our battles are fought, showed a consistent antiphysician bias throughout the 1982-1983 session. In the election we generously supported Bornheimer's opponent, Peter P. Garibaldi (R-Cranbury). Today, Garibaldi is a senator.

The amount of contributions we were able to raise does not simply put MSNJ "on the map" in the realm of political action—it reflects medicine's legitimate growing interest and involvement in legislation that affects the livelihood of physicians and the well-being of their patients. Keep up the good work!

Clark Martin
Joseph W. Katz
MSNJ Lobbyists

ONLY DALMANE®
flurazepam HCl/Roche
IMPROVES SLEEP...



WITH COMPLETE SLEEP LABORATORY PROOF[1-5]...

Copyright© 1984 by Roche Products reserved.

N ALL THESE WAYS

- Rapid sleep onset[1-6]
- Effective for middle-of-the-night and early-morning awakenings[2,5]
- Undiminished efficacy for at least 28 nights[2-4]
- Patients usually awake rested and refreshed[7-9]
- Avoids rebound insomnia after discontinuation of therapy[3,5,10-12]

Caution patients about driving, operating hazardous machinery or drinking alcohol during therapy. Limit dose to 15 mg in elderly or debilitated patients. Contraindicated during pregnancy.



AND THE PREDICTABILITY THAT COMES WITH EXPERIENCE

FOR EFFECTIVE RELIEF OF INSOMNIA

DALMANE® (IV)

flurazepam HCl/Roche

STANDS APART



15-MG/30-MG CAPSULES

See next page for references and summary of product information.

References: 1. Kales J *et al: Clin Pharmacol Ther* 12:691-697, Jul-Aug 1971. 2. Kales A *et al: Clin Pharmacol Ther* 18:356-363, Sep 1975. 3. Kales A *et al: Clin Pharmacol Ther* 19: 576-583, May 1976. 4. Kales A *et al: Clin Pharmacol Ther* 32:781-788, Dec 1982. 5. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 6. Kales A, Kales JD: *J Clin Pharmacol* 3:140-150, Apr 1983. 7. Monti JM: *Methods Find Exp Clin Pharmacol* 3:303-326, May 1981. 8. Greenblatt DJ *et al: Sleep* 5 (Suppl 1):S18-S27, 1982. 9. Kales A *et al: Pharmacology* 26:121-137, 1983. 10. Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther* 21:355-361, Mar 1977. 11. Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. 12. Amrein R *et al: Drugs Exp Clin Res* 9(1):85-99, 1983.

Dalmane® Ⓝ
flurazepam HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided, with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

This Publication is available in Microform.



University Microfilms International

Please send additional information
for _____
Name _____
Institution _____
Street _____
City _____
State _____ Zip _____

300 North Zeeb Road
Dept. P.R.
Ann Arbor, Mi. 48106

WHY AMA?

Residents and medical students now have a strong voice in organized medicine. Through the Resident Physician Section and the Medical Student Section, these two groups participate in the policy making process of the AMA and communicate their concerns. Developing future leadership in organized medicine: it's one more good reason why you should be a part of the AMA.

To Join,
Contact your county or state medical society or write: Division of Membership, AMA, 535 North Dearborn Street, Chicago, Illinois 60610 or call collect, (312) 751-6196.

AMA
AMERICAN MEDICAL ASSOCIATION

SPECIAL ARTICLE

AMA Principles of Medical Ethics

The medical profession long has subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

Principle I: A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.



Of all the seven Principles, this is the one that applies specifically to our profession. In the other six, banker, lawyer, or architect could be substituted for physician, and client for patient, and the statement would be cogent for that particular profession. But the fact that only a physician is entrusted with "laying hands on" the human body makes the first Principle especially applicable to medicine. Of all the tasks allotted to man, none is more privileged than ours in dealing with persons in their raw state, as it were, and facing the intimate problems of people head on. This intimacy is so sacred that "unconsented touching of another person" is enough to warrant an allegation of battery. Other professions deal with ideas, things, money, dwellings, movement of objects, communication of thoughts, means of pleasure, and satisfactions of the soul. Ours deals directly with people—as someone said, we handle "diseases of the skin and its contents." And to this we are dedicated or set apart, regardless of the specialty chosen or the type of remuneration accepted. The pathologist is no less considerate of the body he/she dissects than the pediatrician is of the newborn baby he/she cares for. Whatever our area of expertise, we are committed to provide capable assistance and meet the needs of those we serve.

This first Principle guarantees that we do this with a deep feeling of sharing our patient's suffering or offering the last ounce of mercy. In so doing we recognize the inherent worth of each individual patient—no one should be excluded from our regard. Our concern should be for all, but particularly for those who seek help in bearing the burden of sickness or injury. No problem should be beyond our solving, no person beyond our care. Even a doctor going through an illness realizes that one hand cannot wash itself, but a fellow physician can help make us whole. We can do no less for any other patient.

The fulfillment of this first Principle is the ultimate in following the golden rule: "In everything, do unto others as you would have others do unto you."

John S. Madara, M.D.
Past President, MSNJ

Principle II: A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.



I think we logically can break this Principle down into two separate components. The first component is the obligation of the physician to deal honestly with patients and colleagues and second is the obligation of the physician to expose physicians who are deficient in character or competence or who engage in fraud or deception.

I can think of no profession in which the need for absolute honesty is greater. Honesty in medicine involves a careful evaluation of one's own knowledge and limitations and an unwillingness to extend one's efforts beyond those established boundaries. It requires truth in every area of professional relationships; in dealing with patients, colleagues, hospital staff, patient advocate, and fiscal intermediaries. The physician must be extremely careful in the use of ancillary medical services that the indication always is the patient's need, particularly when those services lead to financial gain for the physician.

Physicians must accept their responsibility to their patients, the profession, and the general public to keep the "medical house" in order by taking action to expose and to bring appropriate disciplinary action to physicians whose standards of practice are less than those that have been outlined above. The concept of honesty in medicine is in absolute contradiction to the practice of medicine that is beyond the area of a physician's knowledge, skill, or expertise or to the obvious dishonesty that must be involved in fraud or deception in any area of medical practice.

We might summarize in the words of the playwright "This above all else, to thine own self be true then it follows as the night the day, thou canst be false to any man."

Physicians who are "impaired" because of mental illness, physical handicaps, or substance abuse fall into a special category. These doctors must be exposed as well! The thrust however, should be to rehabilitate or retire these physicians who are victims of an illness that they did not seek. Disciplinary action seldom is needed.

David I. Canavan, M.D.
Medical Director
Impaired Physicians Program, MSNJ

Principle III: A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interest of the patient.



Principle III was incorporated by the AMA House of Delegates into the current version of the Principles of Medical Ethics which were adopted in 1980. The explanatory material, accompanying the revision and published in *Current Opinions of The Judicial Council of the AMA—1982,* is helpful in interpreting the intent of this particular statement.

Section 1.02, *The Relation of Law and Ethics* of that edition, states, in part, "Ethical standards of professional conduct and responsibility may exceed but are never less than, nor contrary to, those required by law . . . . Ethical pronouncements of the Judicial Council and the House of Delegates should not be so interpreted, construed, or applied as to encourage conduct which violates a valid law."

It appears to me that the AMA attempted to resolve the occasional conflict that professionals of all types have experienced between law and ethics. It determined that as a professional society the only course available to it was to require adherence to and respect of the law, while requesting and seeking changes that would work toward the protection of the best interest of the patient.

Principle III, therefore, holds that physicians are to resolve conflicts between law and ethics in favor of the law. It places a further burden on the physician, however, by declaring an affirmative duty to seek changes in any legal requirements which are contrary to the best interest of the patient.

Vincent A. Maressa, J.D.
Executive Director, MSNJ

Principle IV: A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.



The medical profession's regard for patient confidentiality can be traced to the oath of Hippocrates. The modern counterpart to the Hippocratic Oath is Principle IV of the AMA Principles of Medical Ethics. What do the various parts of Principle IV mean to me?

First, a patient has a right to assume that information revealed to a physician will not be transmitted without his/her consent. A physician who violates this trust not only acts unethically, but also may be held civilly liable for such an unauthorized disclosure of confidential patient information. The rationale behind this physician duty to safeguard confidences stems from the necessity that patients seeking medical attention should feel free to reveal private matters to their physician without fear of unwarranted disclosures. The strength and value of the patient-physician relationship must be based on this safeguard.

What about respect for the rights of colleagues? This ethical guideline is akin to the golden rule which states "Do unto others as you would have others do unto you." In essence, physicians should try always to be open-minded and respectful of each other and avoid letting personal differences compromise patient care. Patient care always comes first and we should not let our personal convenience interfere with this necessity. In reality, physicians respect those physician colleagues the most who are guided by the patient's welfare and who dispatch their clinical duties with skill, compassion, and the least amount of complaining.

Finally, what does it mean to respect the rights of other health professionals? To me, this means that physicians should accord an appropriate measure of respect and acknowledgement for the other health professionals involved in caring for their patients. This most obviously includes members of the nursing staff, as well as technicians, aides, orderlies, volunteers, housekeepers, and ambulance personnel. They all have much to offer our patients and we could not function without their cooperation and assistance. They deserve to know we appreciate their efforts.

James E. George, M.D., J.D.
Director
Department of Professional Liability, MSNJ

Principle V: A physician shall continue to study, apply, and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professonals where indicated.



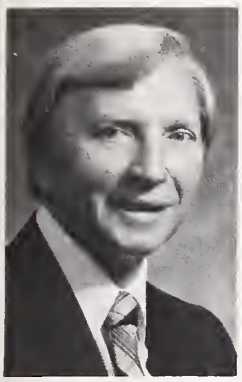
Principle V actually embodies several ideas. First, it reminds the physician that a commitment to the healing arts means commitment to a lifetime as a student. For the physician, the educational phase never ends; now, more than ever, medical education is a continuum, beginning in undergraduate college, extending through medical school, residency, and the entire career of practice. Medical education is integral to medical practice, utterly necessary to its success. It is not an option, not an individual decision, but an absolute requirement for the conscientious physician.

Next, Principle V reminds us that a physician may not keep his/her own counsel and act thereon. Particularly in the context of contemporary medicine, the physician must share knowledge with colleagues and, conversely, seek colleagues' knowledge in the patient's best interests.

Lastly, Principle V reminds us that the physician must continually teach—teach colleagues, students, patients, family members, and society in general. Only through fulfilling the role of doctor, which literally means teacher, does the physician meet the moral obligation in its broadest sense.

Stanley S. Bergen, Jr., M.D.
President, UMDNJ

Principle VI: A physician shall, in the provision of appropriate patient care except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.



Recently, I was told that Principle VI of the AMA Principles of Medical Ethics was a violation of the Civil Rights Act because the exercise of this moral right on our part interferes with the legal rights of others to select a doctor of their choice. Until that moment, I had taken this Principle for granted. I realize now how important Principle VI is and how fragile our hold on the exercise of our civil rights. The law, to some extent, already has eroded this Principle. We are forced by law to associate professionally with others whose training is not comparable to our own.

We certainly find our choice of environment in which to serve drastically curtailed as regionalization of medical care removes more and more facilities from the list of those which are available to us. The coming glut of physicians will limit these choices by our younger colleagues even more.

Despite these obvious reductions, we have not yet lost our freedom. To date, the government has not ordered us to serve any individual nor any group of patients against our will.

Freedom is seldom lost in a coup. It is milked away bit by bit and often we are unaware of the teethmarks.

Despite efforts of MSNJ to stop it, Governor Thomas Kean recently signed into law a bill requiring our carriers and our hospitals to report to the New Jersey State Board of Medical Examiners any liability claim settled for more than $25,000. We fought this bill for 18 months yet most doctors found out about it only recently when they were notified of it by their hospitals. The popular no-fault insurance bills contain requirements for mandated fee schedules.

We must distinguish carefully between the legitimate interest of the public in the proper employment of our skills and the mandated use of those skills. Point of view is important. What the public perceives as legitimate interest may be construed by us as illegitimate intrusion.

Quality audits by our peers in our hospital is legitimate; reduction or loss of hospital privileges because we fail to admit patients with high revenue DRGs is illegitimate. The requirement that we perform free service in hospital clinics in return for privileges is legitimate; forcing us to accept indigent persons as private patients in our offices on a capitation basis is illegitimate. Giving our patients sufficient time to satisfy their fears about their disease is legitimate; requiring that we spend useless time and frighten patients by explaining every possible far-out, one-in-a-million complication from a medication or a procedure is illegitimate. Exercising our options to refer our patients to therapists, chiropractors, or other paraprofessionals if it is in the best interest of the patient is legitimate; mandating that we accept those whose training is not comparable with ours as equals on the executive committees of our hospital staffs is illegitimate.

If you read carefully all the Principles, you quickly can see that none can be effective unless Principle VI is preserved. Its preservation requires a willingness to sacrifice time and money and a commitment to practice compassionately so that those who wish to reduce our profession to the level of a public utility cannot use our own actions against us.

In 1790, John Philpot Curran stated, "The condition upon which God hath given liberty to man is eternal vigilance which condition if he breaks, servitude is at once the consequence of his crime and the punishment of his guilt."

Alexander D. Kovacs, M.D.
President, MSNJ

Principle VII: A physician shall recognize a responsibility to participate in activities contributing to an improved community.



That a physician should assume responsibility for participation in activities contributing to an improved community is a principle of medical ethics. Nevertheless, only a small percentage of physicians participate in community activities. This most likely is due to the overwhelming responsibilities associated in caring for patients, demanding maximum energy, fulltime and constant training. Also, the typical medical student was so steeped in premedical curricula that the student often lacked perspectives of national and international problems. Preoccupation with the need to pass every science course often precluded the opportunity to engage in political, social, and community activities. In general, physicians, medical faculty, and medical students become carbon copies of each other, resulting in narrow perspectives due to focusing on the need to succeed and compete in their field with always more and more to learn. All of this is totally understandable to those of us who have struggled through the system.

Furthermore at the time of graduation, the typical medical student is in heavy financial debt. Thereafter, the debt is furthered by the financing of a new office, insurance, a car, and setting up a practice. Young physicians are consumed by these burdens. In addition, the growing surplus of doctors has added another anxiety that one might fail.

Nevertheless, the responsibility of physicians to become involved in community affairs remains. Respect, intelligence, and potential leadership qualities often are associated with the profession, and these characterisitics lend themselves nicely to community participation. Community service can be extremely variable. School boards, little league football physicians, library committees, political parties, specific major projects such as nuclear or antinuclear groups, cancer societies, volunteer ambulance or volunteer fire departments, and numerous other organizations are worthy of consideration. Not only can the doctor provide ideas and leadership to the group but often will meet laypeople of good meaning, which is a wonderful experience in itself. Even without consiously building a practice, these exposures can only help increase your referral base.

In summary, it is not easy to find a proper perspective in life, especially if you are a compulsive physician. Following one's responsibility to family, then to profession, and finally to community one can only bring new meaning to life. The line between the fortunate and unfortunate is ever so thin that only by the grace of God have physicians remained above this line. Yet, men so quickly forget from whence they came. No longer can the medical profession live like an ostrich. We must become involved with every aspect of society. It is part of our oath and heritage.

Leon G. Smith, M.D.
St. Michael's Medical Center

JUST ONCE-DAILY FOR INITIAL THERAPY IN HYPERTENSION

Unique, once-daily formulation providing comprehensive cardiovascular protection

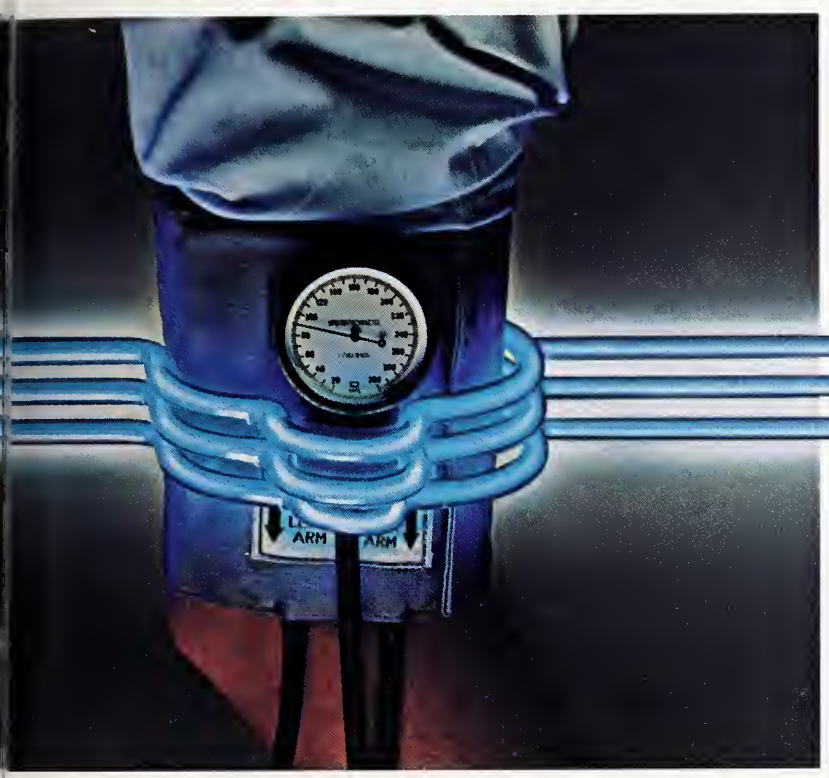
INDERAL LA offers the antihypertensive and cardiovascular benefits of INDERAL–with the additional advantage of convenient, single daily dosage. With a unique controlled-release formulation, INDERAL LA (propranolol HCl) provides sustained plasma levels and consistent, 24-hour beta blockade.

Smooth 24-hour blood pressure control

In controlled clinical studies, INDERAL LA effectively maintained systolic and diastolic blood pressure reductions with single daily dosing.

Avoids the potassium loss associated with diuretics

INDERAL LA controls blood pressure without the problem of hypokalemia often associated with long-term diuretic therapy. Like conventional INDERAL, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.



THE ONE™ TO COUNT ON

Start with 80 mg once daily...

Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. When converting patients from other beta blockers, including INDERAL tablets, start with the nearest milligram equivalent of INDERAL LA once daily and evaluate clinical results to determine if dosage adjustment is necessary. For arrhythmias, use conventional INDERAL (propranolol HCl) tablets.



80 mg 120 mg 160 mg

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

Please see next page for brief summary of prescribing information.

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) *LONG ACTING CAPSULES*

Ayerst®

The one to count on for HYPERTENSION, ANGINA and prevention of MIGRAINE.

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION SEE PACKAGE CIRCULAR.)*
INDERAL® LA BRAND OF propranolol hydrochloride
(Long Acting Capsules)
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta-blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therap prior to major surgery is controversial. It should be noted, however, that the impaired ability c the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesi and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta receptor agonists and its effects can be reversed by administration of such agents, e.g dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported wit beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the ap pearance of certain premonitory signs and symptoms (pulse rate and pressure changes) c acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be mor difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptom of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have bee reported in which, after propranolol, the tachycardia was replaced by a severe bradycardi requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. General: Propranolol should be used with caution in patients with impaire hepatic or renal function. INDERAL is not indicated for the treatment of hypertensiv emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patient should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal ma lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reser pine should be closely observed if INDERAL is administered. The added catecholamine blocking action may produce an excessive reduction of resting sympathetic nervous activit which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostati hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies i both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significan drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visua disturbances; hallucinations; an acute reversible syndrome characterized by disorientation fo time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE — At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

8688/883

Ayerst® AYERST LABORATORIES
New York, N.Y. 10017

The Area Health Education Center Program

MERWYN A. LANDAY, D.D.S., BENJAMIN L. COHEN, D.O.,
RICHARD C. REYNOLDS, M.D., Camden*

The Area Health Education Center (AHEC) Program is a decentralized effort to improve health professions education in southern New Jersey and eventually the health status of the population of this region. It is intended to correct the deficit in the type and numbers of education programs for the health professions in the region by linking the educational and training programs of the University of Medicine and Dentistry of New Jersey to community hospitals, local affiliated educational institutions, and local health providers in southern New Jersey.

The Area Health Education Center Program in New Jersey consists of two principal components: the University of Medicine and Dentistry of New Jersey (UMDNJ) with its cooperating and participating schools, and three Area Health Education Centers (AHECs). The three AHECs encompass a region that includes the eight counties of southern New Jersey (Figure 1).

The UMDNJ schools participating in the AHEC Program include the New Jersey School of Osteopathic Medicine, Rutgers Medical School, New Jersey Dental School, and the School of Health-Related Professions. The New Jersey School of Osteopathic Medicine developed and secured the grant and is the management agent for the program. Among the other institutions to participate in the New Jersey AHEC Program are 12 affiliated schools, 22 hospitals or major health care providers, over 30 preceptor offices, and more than 20 community organizations.

The AHEC Program is a decentralized effort to improve health professions education, the geographic and specialty distribution of health manpower, and, eventually, the health status of the population of southern New Jersey. It is intended to correct the deficit in the type and numbers of health professions education programs in the region as well as to improve the coordination and use of existing resources by linking the educational and training programs of the University of Medicine and Dentistry of New Jersey to community hospitals, local affiliated educational institutions, and local health providers. Using this partnership approach, the program provides training that specifically addresses the health personnel needs of particular communities of southern New Jersey.

Southern New Jersey has two related problems in health status and health manpower. The health status of the eight counties of southern New Jersey is below the state average, and there is uneven distribution and some shortages of health manpower. And, until recently, health professions education institutions and resources virtually were nonexistent in this region.

During the first three years (1978 to 1981) of the New Jersey AHEC Program, the Camden AHEC, an urban area health education center with an emphasis on Camden City, was developed in Camden County. This past year, planning was accomplished for two additional AHECs to cover the remaining seven counties of southern New Jersey. The new Garden AHEC covers Gloucester, Salem, and Cumberland counties in southwestern New Jersey and has urban and rural components. The new Shore AHEC covers Burlington,

*From UMDNJ, where Dr. Landay is Program Director, UMDNJ-Area Health Education Center Program, Dr. Cohen is Dean, UMDNJ-New Jersey School of Osteopathic Medicine, and Dr. Reynolds is Dean, UMDNJ-Rutgers Medical School. Correspondence may be addressed to Dr. Landay, UMDNJ-AHEC Program, 300 Broadway, Camden, NJ 08103.

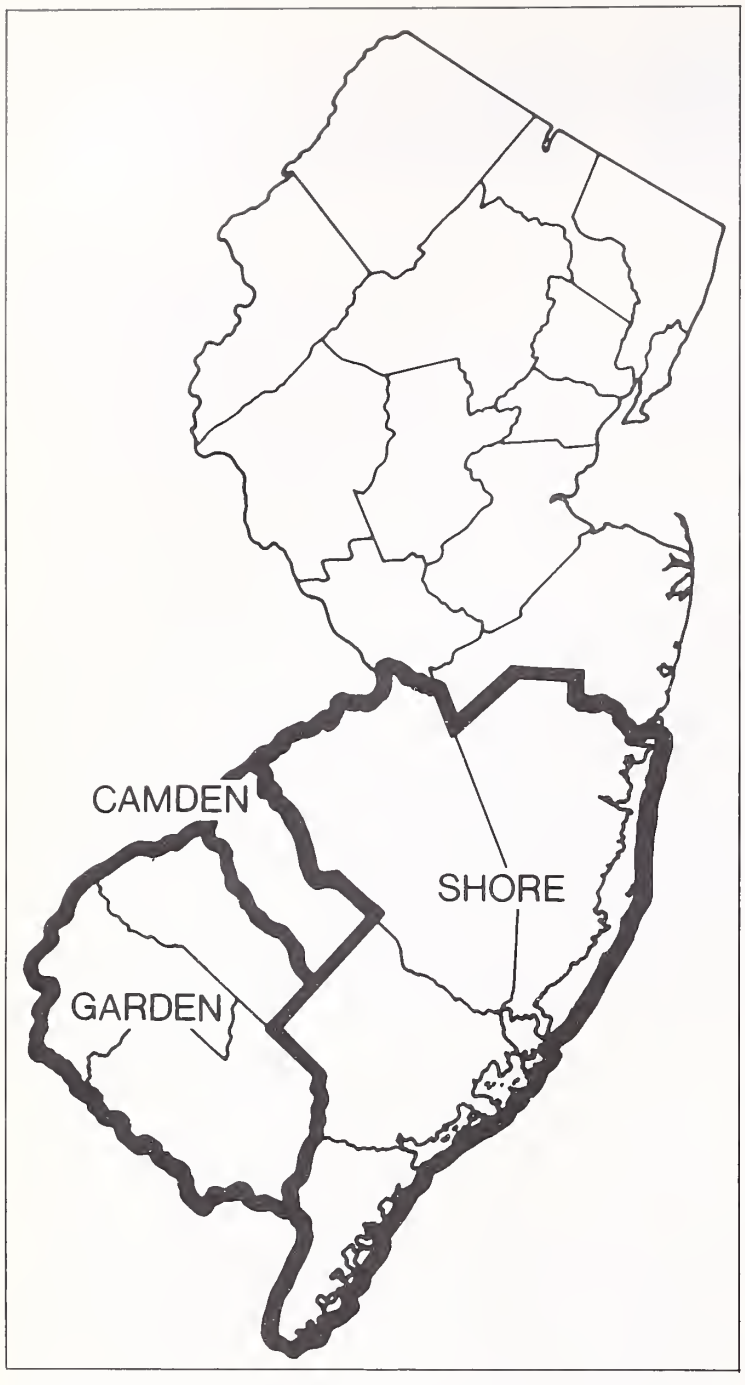


Figure 1—The three AHECs encompass a region that includes the eight counties of southern New Jersey.

Ocean, Atlantic, and Cape May Counties in southeastern New Jersey and has urban, rural, and geriatric components.

Each of the three AHECs in the program is operated by a corporate entity independent from UMDNJ. The Camden AHEC is administered by Camden AHEC, Inc., a not-for-profit community corporation formed expressly for the purpose of conducting a regional educational center in Camden County. The Garden AHEC is administered by the Bridgeton Hospital Association, which is an independent corporation that operates Bridgeton Hospital in Cumberland County. The Shore AHEC is administered by the Atlantic City Medical Center, which is a hospital with two divisions in Atlantic County. Both of these are community hospital corporations which have adopted, as one of their additional functions, the operation of an area health education center.

Large numbers of students of all types are having significant portions of their formal training provided in settings in southern New Jersey. This includes undergraduate osteopathic and allopathic medical students, osteopathic and allopathic postgraduate students, undergraduate and graduate dental students, nurse practitioners, nurse midwives, mental health workers, social workers, and a wide variety of allied health professionals. In addition, large numbers of continuing education programs are being conducted in the previously professionally isolated and underserved southern New Jersey region to improve the quality and other important features of the health manpower and health services of the area. These include extensive activities in continuing education, health education, prevention, nutrition, National Health Service Corps support, minority recruitment into health professions, learning resources development, and health care management.

The intention of the UMDNJ-AHEC Program is to continue the progress already achieved in Camden County and to begin to achieve the same results in the remaining seven counties of southern New Jersey.

THE REGION

Over 1.85 million people live in the eight southern New Jersey counties which comprise this AHEC Program region. Seventy-two percent of this population are urban residents and 28 percent are rural residents.

The major urban concentration in this area, Camden City, has been ranked as the ninth most distressed city in the nation on the basis of the percentage of citizens living in poverty, the percentage of pre-1940 housing, and the rate of population decline. Vineland-Bridgeton-Millville, the second largest metropolitian area in the region, recently was ranked as very nearly the worst metropolitian area in the United States in which to live (267 out of 277 metropolitan areas), comparing economics, housing, crime, education, health care, recreation, transportation, climate, and terrain.[1] In Atlantic City, the third largest city in the region, 71.3 percent of Atlantic City public school pupils, a few years ago, were recipients of Aid to Families with Dependent Children. In addition, the rural residents of southern New Jersey have high rates of unemployment and high numbers of families below the poverty level because of the troubled farm industry.

In 1979, two general indices of health status, the Standardized Mortality Ratio (SMR) and the Years of Life Lost Index (YLL), revealed that the health status of the residents of southern New Jersey is poor. Among the 200 health service areas (HSAs) across the country, southern New Jersey ranked worse than 156 others in general health status.[2] Parts of the area experience generally higher than average morbidity and mortality rates, high infant mortality, and other specific indicators of poor health status. In addition, poor access to health care exists in the region due to economic, cultural, linguistic, geographic, and transportation barriers. For portions of the population of the region, access largely is limited to crisis care, with little preventive medicine, early detection of disease, or health education.

Of the eight-county southern New Jersey areas, five counties had portions of their region classified as primary care Health Manpower Shortage Areas (HMSA) or Medically Underserved Areas (MUA). All of the 20 census tracts in the city of Camden have been designated as primary care HMSAs. In addition, areas of southern New Jersey have only 1 primary care physician per 3,500 to 5,000 population, and some areas have even less than 1 physician per 5,000 population.[3] The New Jersey Department of Higher Education projected the need for an increase of 25.3 percent or 680

physicians by 1985 for the southern New Jersey area,[4] if foreign medical graduates are restricted. In addition, there is a need for other health care professions manpower in certain parts of the region such as nurse practitioners, dentists, nurses, and allied health workers of many types.

Finally, until the arrival in 1978 of the New Jersey AHEC Program and the recent beginning of the development of a southern campus of UMDNJ in Camden County, there was a virtual absence of health professions educational programs in southern New Jersey.

GOALS

The goals of the UMDNJ-AHEC Program are to plan, develop, and operate area health education centers in the eight counties of southern New Jersey in order to: improve the supply, distribution, quality, utilization, and efficiency of health manpower in the health service delivery system and ultimately the health of the residents; to accomplish this through the extension and regionalization of educational responsibilities of currently existing health professions schools.

ORGANIZATIONAL STRUCTURE

The University of Medicine and Dentistry of New Jersey is the state-supported system for health professions education for New Jersey. It is a multicampus institution for educating health personnel with more than 2,000 students enrolled in doctor of medicine, doctor of osteopathy, doctor of dental medicine, doctoral and master of science programs, and many hundreds more in allied health programs, with campuses in Newark, Piscataway, and a newly developing campus in Camden. UMDNJ serves as the recipient of the AHEC Program cooperative agreement. One of its components, the UMDNJ-New Jersey School of Osteopathic Medicine, is the cooperating school, as well as the management agent for the program. The organizational structure of the program is illustrated in Figure 2 and is modeled on federal recommendations to carry out the mandate of the AHEC Program legislation designed to assure a significant non-university voice in AHEC program functioning.

The UMDNJ-New Jersey Dental School and the UMDNJ-School of Health-Related Professions both are participating schools in the program. The UMDNJ-Rutgers Medical School, which in the past was involved only for the purchase of services for which it had unique resources, intends to increase its role in the program as the Garden and Shore AHECs become operational.

ACCOMPLISHMENTS IN MEETING FEDERAL AHEC REQUIREMENTS AND PROGRESS TO DATE

The UMDNJ-New Jersey AHEC Program has met all of the requirements in Section 781 of Public Law 94-484 and associated Rules and Regulations, and the Program Guide for Area Health Education Center Programs. Meeting these requirements and regulations was considered to be the minimum acceptable performance for this program.

The real accomplishments and richness in the UMDNJ-AHEC Program are in the many new educational programs and activities that go beyond the basic 781 requirements. For example, 12.8 percent, rather than 10 percent, of the clinical education of the New Jersey School of Osteopathic Medicine now occurs in AHEC settings. Although only two other health professions schools other than the cooperating school are required to participate in an AHEC program, nine schools now rotate students into the Camden AHEC alone

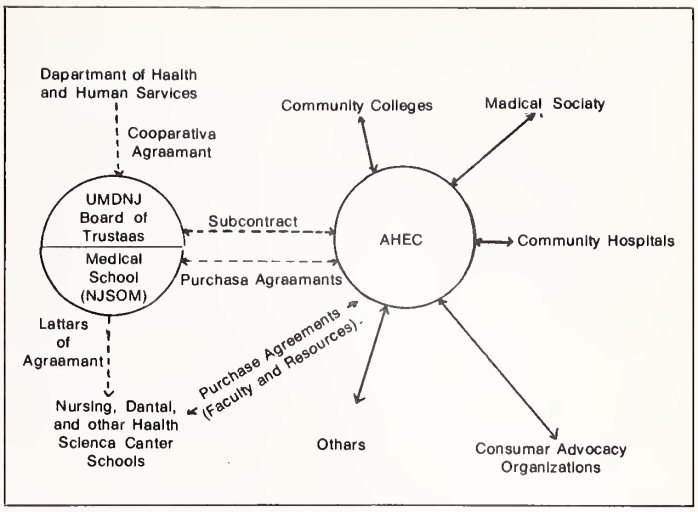


Figure 2—The organizational structure of the UMDNJ-AHEC Program.

for clinical experiences as a result of the New Jersey AHEC Program. Although only 75 percent of the funds awarded to the program must pass to the centers, 81 percent in fiscal year 1983 and 85 percent in fiscal year 1984 will go to the centers. Although either a nurse practitioner or physician's assistant program is required, new clinical training programs for nurse-midwives, nurse-practitioners, and physician's assistants have been brought into the region. A new family practice residency has been started which had over 20 applicants for seven positions this past year. Innovative continuing education programs have been offered in content areas relating to practice in underserved areas. Nutrition education has been newly provided to the region. Health professionals now receive skills training in health education important to the promotion of health in the area. National Health Service Corps members receive assistance while locating and practicing in the area, as well as a potential faculty appointment at UMDNJ-NJSOM and UMDNJ-RMS. Thousands of minority and disadvantaged high school students have been exposed to health career opportunities. The Center Board of Directors and Center and Program Advisory Committees have involved extraordinarily large numbers of health professionals and broad community constituencies in developing educational programs needed in this region, and providing many of the resources for their support.

In this past year, 93 undergraduate osteopathic medical students spent a total of 11,928 student hours in AHEC settings and institutions in the region. The AHEC Program provided supporting resources for 105 existing and new primary care residents and rotating interns. As part of the developing Rutgers Medical School of Camden, 70 allopathic undergraduate medical students spent rotations in southern New Jersey, and 12 Fifth Pathway students spent a full year in the Camden inner city. All 86 dental students from the northern part of the state rotated through the AHEC region for a total of 1,204 student hours of instruction in AHEC settings in the region. Extensive rotations were provided in nursing, allied health, and social work education. These included nurse midwifery students full time for 15-week rotations, nurse practitioner students for 18-week rotations, physician's assistant students for 4 weeks full time, social work graduate students for three days a week for a year, and dietary technician students for 60 hours each. Other allied health rotations occurred in mental health,

physical therapy, and dental hygiene, for a total of approximately 6,000 student hours of clinical experience in the AHEC region. Over 200 students from various disciplines participated in formal educational programs in health care management. In nutrition education, 85 students were involved in direct instruction and clinical experiences in the region. Over 50 minority and disadvantaged students were involved in extensive health careers development programs for over 2,500 student hours of educational experience. In continuing and other education in the past two years, over 75 courses have been conducted in Camden with 2,463 participants, for over 9,000 participant hours. In addition, over 2,000 students in various high schools throughout the region were involved in health careers awareness programs.

As a result of the AHEC Program, a number of other significant accomplishments have occurred. Nursing education at the graduate level has increased considerably in the region with the development of a nurse-midwifery, a nurse practitioner, and a continuing education effort. The cooperating medical school now accepts the AHEC rotation into underserved areas as part of their standard curriculum. A large number of clinical rotations have started in the region which are expected to lead to a more favorable distribution of health personnel in southern New Jersey. Partnerships have been established between many health professions training institutions and local health providers and educational institutions in the region. The AHEC Program has provided the link between the health sciences centers in the northern and middle parts of the state and the underserved areas of southern New Jersey. An enhanced professional environment has begun to develop for health professionals in southern New Jersey which should make this area a more attractive location in which to practice. The University has begun to help increase the skills of practitioners and administrators in health care delivery with its health care management training. And, most importantly, the AHEC Program through its broad extension of educational programs and the University presence into this previously neglected area has begun to address the health manpower needs of the area.

SCOPE OF FUTURE WORK

The next two years will move the New Jersey AHEC Program further towards a three-center program. In 1983, the Camden AHEC entered its fifth year and continues to function at a fully operational level through increased local support. The Garden and Shore AHECs will enter their developmental years and continue to form the necessary linkages and partnerships, as well as design the educational programs needed in this region. In addition, during this next year, continuing education and the start of student rotations in a number of disciplines will begin in the Garden and Shore AHECs. In 1984, the Garden and Shore AHECs will enter their operational years and conduct the wide variety of educational programs developed for their regions.

During 1983, formal educational programs conducted in the AHEC region include 20 disciplinary areas and over 900 students. Three hundred forty-eight students are from osteopathic and allopathic undergraduate and postgraduate medical education, 89 students from dental education, 54 students from allied health, and 85 students from nutrition education. In addition, social work education involves 60 students; health care management, 200 students; and health education, 35 students. Also, a total of 10,812 participants are involved in almost 30,000 hours of continuing education programs in the fields of medicine, dentistry, nursing, allied health, health care management, and multidisciplinary topics.

During this next year, the New Jersey AHEC Program will place emphasis on the development of the Garden and Shore AHECs. Both centers will continue the formation of partnerships with potential participating institutions as well as piloting new rotations for students needed in the region. The development of a geriatric emphasis for the Shore AHEC will be continued so that appropriate student experiences are planned and readied for implementation. Emphasis on nursing education is planned throughout the region with increased activity in innovative education which attempts to keep nurses in the work force and increase their job satisfaction. Efforts also will be made to develop the region as a model for NHSC placements and innovative extensions of learning resources into this region through an existing consortium will be pursued.

The extension into the remaining seven counties of southern New Jersey during these next three years, besides addressing the needs of the population of this area, will increase the number of students enrolled in AHEC-supported activities and enhance student experiences by providing rotations in a variety of sites and an opportunity to work with urban, rural, migrant, and geriatric patient populations. With the types and numbers of educational programs projected, UMDNJ will continue to develop an increased presence and responsibility throughout the region and continue to bring about the necessary interinstitutional change and resources needed to address the health education and health manpower needs of southern New Jersey.

PROJECTED OUTCOMES

The UMDNJ-New Jersey AHEC Program will achieve a number of important organizational, educational, and community outcomes in the region.

Organizational outcomes include the following:

1. Three AHEC regional education centers will have been developed.
2. The University of Medicine and Dentistry of New Jersey will have another structure to provide educational programs to the complete southern New Jersey region.
3. Multiple linkages and partnerships in educational programs will have developed between components of UMDNJ and community hospitals, local affiliated educational institutions, and local health care providers.
4. The numbers of primary care health professions training programs and students will have been increased.
5. Significant institutional change will occur in the traditional pattern of health professions education.

Educational outcomes include the following:

1. UMDNJ will have regionalized its medical, dental, and allied health education programs into the southern New Jersey area.
2. The deficiency in health professions educational programs in southern New Jersey will have been relieved.
3. Coordination of the education and training of medical, dental, nursing, social work, mental health, and allied health workers in primary care will have increased.
4. Coordination and increase of the quality of continuing education will have occurred throughout the region.
5. Coordination and integration of UMDNJ health professions education programs with local health professions education programs will have increased.
6. Important educational experiences in primary health

care with urban, rural, and geriatric populations will have been added to the educational programs of UMDNJ and affiliated schools.

7. Highly needed academic programs will have been developed in a most cost-effective manner through the combination of resources in multiinstitutional partnerships.

Community outcomes include the following:

1. Professional isolation will be reduced and an improved professional environment will have been developed in underserved areas of southern New Jersey.

2. Retention of students and residents trained in southern New Jersey will be improved.

3. Geographic distribution of primary care health professionals will be improved.

4. Needed health professions educational programs will have been extended into the underserved communities in the region.

5. The supply of primary care physicians and other types of health manpower needed in the underserved areas of the region will have increased.

6. The quality of the health professionals practicing in underserved areas will be improved.

7. Access to primary health care services for residents in the underserved areas of southern New Jersey will increase.

8. There will be larger numbers of representatives of minorities and disadvantaged populations in the health professions of the region.

9. Health care practices in the region will be improved.

10. The health status of the residents of southern New Jersey ultimately will improve.

SPECIAL FEATURES OF THE PROGRAM

The AHEC Program in New Jersey has several special features:

1. **Collaboration between Osteopathic and Allopathic Physicians.** The development of a multiinstitutional partnership to establish an AHEC program in southern New Jersey required a concerted effort of the osteopathic and allopathic professions working together to address the health education and health care needs in the community. This represents a significant collaborative effort between these two segments of the medical profession. Although other AHEC programs have osteopathic schools as participants, this is the only program in which an osteopathic medical school is the cooperating school and the management agent working in partnership with a large number of allopathic institutions. This is increasing the cooperation between these two segments of the medical profession in this region.

2. **Pioneering Efforts in Statewide Health Professions Education.** New Jersey is one of the leading states that is developing a statewide university of the health professions with multiple campuses and regionalized education responsibility. The New Jersey AHEC Program provides the final link to this regionalized statewide approach by providing health professions education into the remaining educationally deficient southern part of the state.

3. **Pioneering Efforts in Urban Area Health Education Centers.** The UMDNJ-AHEC Program was one of the earliest urban AHECs when it was established in 1978. In the city of Camden it dealt with perhaps the most depressed and deficient urban area addressed by an AHEC. This extensive experience will be invaluable for use for the urban residents who represent 72 percent of the population in the eight counties of southern Jersey. In addition, this experience is available for use in other urban areas of New Jersey which, with 13 standard metropolitan statistical areas, is the most urbanized state in the United States.

4. **Pioneering Efforts in Health Care Management.** This AHEC program is unique, with its high emphasis on increasing the skills in management in the health care delivery system of the state. This is especially important in a state that has placed its whole hospital industry on a prospective reimbursement system to contain health care costs and is in critical need of skilled management to accomplish this change. In addition, this training has significant implications in cost containment and is providing students with the practice management skills to locate in underserved areas, as well as the patient management skills to treat the special needs of the populations found in these underserved areas.

5. **Pioneering Affiliations with the National Health Service Corps.** Working with the regional office, four NHSC placements were assigned on July 11, 1982, in Camden AHEC Provider settings and will receive appointments to the UMDNJ-NJSOM faculty. These assignees will meet their Corps service delivery requirements, as well as have the professional stimulation and permanent appeal, of an educational role. Once this model is evaluated, the regional office would like to develop additional dual service-educational placements throughout southern New Jersey.

6. **Potential in Geriatrics-Gerontology Education and Service.** The extraordinarily high geriatric populations in the counties of south Jersey, especially along the Atlantic shore, present both a need and an opportunity for New Jersey. This is a severely underserved population. The potential exists to make the Shore AHEC the focus for geriatric-gerontology rotations and training for the UMDNJ system and to secure external funding sources for support.

7. **Extraordinary Cost Effectiveness of the Program.** The benefits and effectiveness of the UMDNJ-AHEC Program are extremely high in comparison to the costs of the program. Larger numbers of students and populations and larger areas are being impacted by the program than projected in the original UMDNJ proposal to the federal government and at funding levels which never have reached near the levels of those requested in the original proposal. In addition, innovative programming is planned to allow the developing Garden and Shore AHECs to meet all Section 781 requirements without high costs. The intent is to provide high quality, noncostly models of area health educations centers in the Garden and Shore regions.

CONCLUSION

The UMDNJ-AHEC Program is critical to the improvement of the health manpower and health status of the residents of southern New Jersey. With its decentralized and regionalized approach to the problem, extending and linking currently existing health professions schools to the local community, it is providing a highly cost-effective approach to the health personnel needs of southern New Jersey.

REFERENCES

1. Boyer R, Savageau D: *Places Related Almanac.* New York, NY, Rand McNally Co., 1981.
2. Southern New Jersey Health Systems Agency: Health Systems Plan, 1979-1984, pp 31.
3. Southern New Jersey Health Systems Agency: Health Systems Plan, 1979-1984, pp 63.
4. New Jersey Department of Higher Education: *Graduate Medical Education Master Plan. Physician Need Projection by Specialty and Geographic Location for New Jersey.* Office of Research and Manpower, 1981.

We're 6,900 New Jersey physicians managing *our own* non-profit liability insurance company — for *our own* sake.

Six years ago, when commercial malpractice insurance premiums went through the roof, the Medical Society of N.J. sponsored 4,400 New Jersey physicians in the doctors' own venture to insure *themselves* at a *realistic cost.*

We invite you to join us.

By eliminating the middleman, minimizing operating expenses, and managing *our own* funds, we *beat the system.* Recently introduced commercial products have had to resort to (ultimately very expensive) short-term gimmicks and "come-ons." Despite their efforts, our membership increased by a full 10% in 1982—that's a testimonial by *600* of your colleagues who recently compared all the currently available alternatives. **Today, our subscribers represent two-thirds of the practicing physicians purchasing insurance in the state.**

We'd like very much to talk to you. You'll discover that a chat with someone with *your interests* at heart can be a real eye opener. Call me, Bill Reilly, Vice President/Policy Holder Services at **800-257-6288.**

*"The **Doctors'** Company"*

Medical Inter-Insurance Exchange of New Jersey

Two Princess Road
Lawrenceville, New Jersey 08648
(609) 896-2404

Infantile Embryonal Carcinoma in Children

PHILIP S. AFFUSO, M.D., and
A. OLUSEGUN FAYEMI, M.D., Teaneck*

We report two children with infantile embryonal carcinoma of the testis presenting as painless testicular enlargement in one case and a clinical picture indistinguishable from a hydrocele in the other. The patients underwent orchiectomy without lymph node dissection or adjuvant chemotherapy.

Primary testicular neoplasms are rare in infancy and childhood. Two to 5 percent of all testicular tumors occur in children and the majority of these make their appearance before the age of two years.[1] Approximately 35 new cases are diagnosed annually throughout the United States.[2] This report concerns the occurrence of primary malignant testicular neoplasms in two children. The lesions were treated by surgery alone with a followup period of one-and-a-half to two years, respectively.

CASE REPORT 1

A two-year-old boy was brought to the emergency room because of painful enlargement of the right scrotum. Two months prior to admission he was diagnosed as having a hydrocele and elective hydrocelectomy had been planned.

Physical examination revealed the right scrotum to be diffusely enlarged and tender. Because of the possibility of an incarcerated hernia, emergency operation was performed through an inguinal incision. At surgery, the right testis was found to be completely replaced by tumor and right radical orchiectomy was performed.

The testis, which measured 4.5 x 3 x 3 cm, showed a smooth and glistening tunica albuginea. Almost the entire testicular substance was replaced by a yellow-gray tumor showing focal hemorrhage, necrosis, and, in areas, a mucoid appearance.

Microscopically, malignant epithelial cells were arranged in glandular forms with prominent papillary pattern (Figure 1). The lumen of some contained lightly eosinphilic amorphous material. The tumor cells usually were hyperchromatic, some showing prominent vacuolated cytoplasm.

The postoperative course was uneventful. He subsequently was referred to Memorial Sloan Kettering Medical Center where detailed investigation revealed no evidence of metastases, hence no further treatment was administered. Two years following surgery, the patient is alive and well. Careful followup has failed to reveal any evidence of recurrence.

CASE REPORT 2

An 18-month-old child was evaluated for a two-week history of painless swelling of the right scrotum. Physical examination revealed that the right testis was diffusely enlarged, nontender, and soft. Transillumination was possible and, therefore, the diagnosis of a hydrocele was entertained although a testicular neoplasm could not be excluded. The preoperative chest roentgenogram, beta unit of human chorionic gonadotropin (HCG) and alpha fetoprotein were all negative.

Exploration through an inguinal incision was performed. The testis was found to be enlarged and replaced by a gelatinous-like tumor. A radical orchiectomy was performed.

The testis measured 3.2 cm in maximum dimension, showed a smooth tunica albuginea, and, on section, revealed replacement of testicular parenchyma by a soft light-pinkish

*From Holy Name Hospital where Dr. Affuso is Attending Urologist and Dr. Fayemi is Attending Pathologist. Correspondence may be addressed to Dr. Fayemi, Holy Name Hospital, Department of Pathology, Teaneck, NJ 07666.

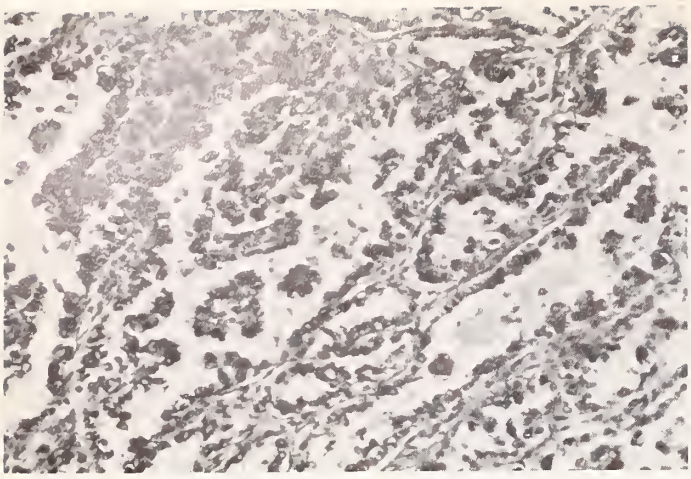


Figure 1—Testicular tumor showing distinct and prominent papillary pattern. The glandular lumens contain eosinophilic material. Many cells show vacuolated cytoplasm (H&E, x100).

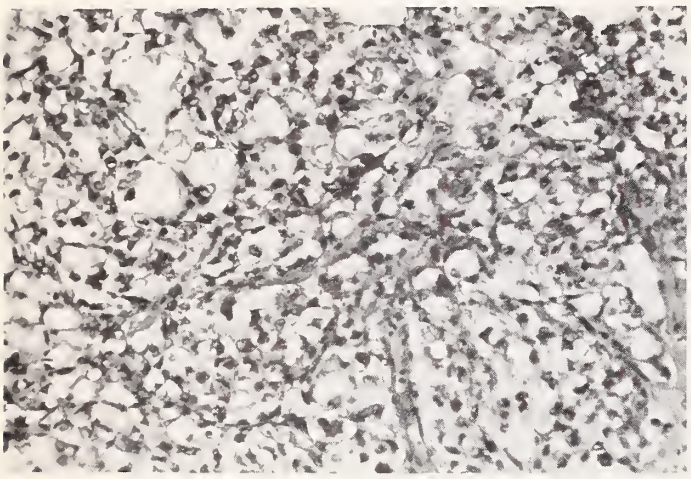


Figure 2—Embryonal carcinoma dispersed in loosely woven masses and forming tubular spaces. Cytoplasmic vacuolation commonly is observed (H&E, x100).

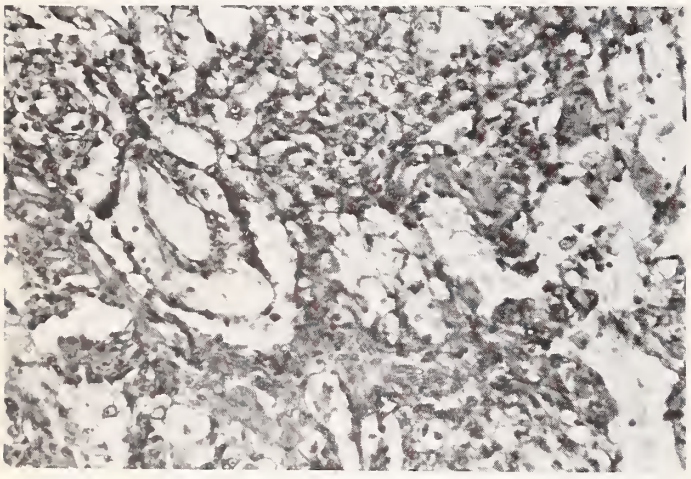


Figure 3—Testicular tumor showing irregular cystic cavities and a Schiller-Duval body (H&E, x100).

tumor with mucoid appearance. The surrounding testicular parenchyma was compressed and atrophic.

Microscopically, the tumor was composed of undifferentiated vacuolated cells disposed in loosely woven masses and forming irregular tubular spaces with small cystic cavities (Figure 2). Present in several areas were Schiller-Duval bodies consisting of a central capillary surrounded by a mantle of cuboidal cells projecting into a capsule lined by similar cells (Figure 3).

The postoperative course was uneventful. Although he was referred to Memorial Sloan Kettering Medical Center for further evaluation, no further treatment was administered. Eighteen months postoperatively, the patient is alive and well without evidence of recurrence.

DISCUSSION

Childhood testicular tumors are so rare that only about 35 new cases are being diagnosed annually in the United States. Because of the infrequent occurrence of neoplasms, scrotal enlargement in childhood usually is assumed to be due to a hydrocele. The diagnosis of a testicular tumor may be missed on initial physical examination, as was shown in the two cases reported in this paper.

About 80 percent of testicular tumors in infancy and childhood are derived from germ cells; three histological patterns of these tumors are recognized: embryonal carcinoma, teratoma, and seminoma.[3] While seminomas are extremely rare, they usually occur beyond the age of ten whereas embryonal carcinomas and teratomas occur most commonly during the first three years of life.

Numerous synonyms of embryonal carcinoma abound, based partly on the histologic morphology and partly on suggested pathogenetic mechanisms: infantile embryonal carcinoma,[4] juvenile embryonal carcinoma,[5] yolk sac tumor, and endodermal sinus tumor.[6] Adult-type embryonal carcinoma, a distinctive histologic and clinical entity, also may occur in childhood. Unlike its infantile counterpart, this tumor has a more aggressive behavior and shows a proclivity to retroperitoneal lymph node metastasis.

Much of the confusion regarding the treatment of embryonal carcinoma stems from the failure of some authors to make a morphologic distinction of the infantile form from the adult type.[7-10] The occurrence of the adult-type lesion calls for orchiectomy combined with retroperitoneal lymph node dissection with or without chemotherapy, whereas with the relatively less malignant course of the infantile embryonal carcinoma, radical orchiectomy with high ligation of the cord often suffices.[11]

It has been suggested that such children be followed closely by clinical examination, monthly chest x-rays, and determination of serum tumor markers (alpha fetoprotein and beta subunit of HCG) in the first year following surgery.

REFERENCES

1. Young PG, Mount BM, Foote FW, Whitemore WF: Embryonal adenocarcinoma in the prepubertal testis. A clinicopathological study of 18 cases. *Cancer* 26:1065, 1970.
2. Excelby PR: Personal communication.
3. Mostofi FR, Price EB: Tumors of the male genital system. *Atlas Tumor Pathology,* Armed Forces Institute of Pathology, Washington, DC, 1973.
4. Mostofi FR: Infantile testicular tumors. *Bull NY Acad Med* 28:684, 1952.
5. Abal MR, Holtz F: Testicular neoplasms in infants and children I. Tumors of germ cell origin. *Cancer* 16:965, 1963.
6. Teilum G: Classification of endodermal sinus tumor (mesoblastoma istellium) and so-called "embryonal carcinoma" of the ovary. *Acta Pathol Microbiol Scand* 64:407, 1965.
7. Puri P, Guiney EJ: Testicular neoplasms in children. *Urology* 9:624, 1977.
8. Drago JR, Nelson RP, Palmer JM: Childhood embryonal carcinoma of testes. *Urology* 12:499, 1978.
9. Smith JP: Testicular tumors in infants and children. *Urology* 2:353, 1973.
10. Hopkins TB, Jaffe N, Colodny A, Cassady JR, Filler RM: The management of testicular tumors in children. *J Urol* 120:96, 1978.
11. Exelby PR: Testicular cancer in children. *Cancer* 45:1803, 1980.

Peroral Esophageal Endoprosthesis for the Management of Incurable Esophageal Carcinoma

M. NURI KALKAY, M.D., BERNARD PANCER, M.D.,
ARNOLD DERMAN, M.D., Holmdel*

A 67-year-old woman presented with progressive dysphagia, weight loss, marked sialorrhea, and recurrent upper respiratory tract infections secondary to a malignant, nonresectable esophageal carcinoma. A quick, immediately effective palliation was achieved, in two sessions, by serial dilatations of the malignant stricture with Eder-Puestow bougies and placement of a peroral esophogeal endoprosthesis. General principles of peroral esophageal endoprosthesis are discussed and compared with other modalities of palliation.

Carcinoma of the esophagus has a poor prognosis no matter what form of treatment is attempted.[1-6] By the time the disease becomes symptomatic and the patient seeks medical advice, most of the cases already are inoperable or nonresectable. Under these circumstances, patients gradually become desperate and will do almost anything in order to be able to eat again.

The primary goal of therapy, for these patients, is palliation.[3-6] The most humane form of palliation is to enable them, with minimal risk, to take their food and continue to eat during their remaining days. Surgical palliative interventions carry unacceptable risks for a palliative procedure, [1-6] and a feeding gastrostomy leaves the patient with a miserable existence. Thus, peroral esophageal endoprosthesis, a simple, quick, effective and low-risk procedure, becomes the treatment of choice in nonresectable obstructing esophageal carcinoma.[3-9, 11]

The purpose of this paper is to present an illustrative case of an obstructing esophageal carcinoma and to share our experience regarding peroral insertion of esophageal prosthesis for palliation purposes.

CASE REPORT

A 67-year-old black female was admitted to the hospital because of progressive dysphagia, marked weight loss, and recurrent upper respiratory tract infections. Solid food dysphagia started six months prior to admission and progressively became worse, so that she was not even able to swallow her saliva. She lost approximately 30 pounds during this time.

She had a past history of moderate, daily alcohol consumption, heavy smoking, and hypertension.

Physical examination revealed an emaciated black female in acute respiratory distress, with marked sialorrhea, constant cough, and wheezing. Blood pressure was 200/110; pulse was 116 and regular, and temperature was 100.6. There was no peripheral lymphadenopathy. The trachea was in the midline. The lung fields were clear to percussion, but re-

*From Bayshore Community Hospital where Dr. Kalkay is Chief of Medicine, Dr. Pancer is Chief of Radiology, and Dr. Derman is Attending, Department of Radiology. Correspondence may be addressed to Dr. Kalkay, Bayshore Community Hospital, Holmdel, NJ 07733.



Figure 1—Carcinoma of the esophagus. A large, irregular, circumferential lesion with shelfing and marked luminal narrowing is demonstrated in the thoracic esophagus.



Figure 2—Barium swallow, following the procedure, demonstrates proper placement of esophageal endoprosthesis without leakage or perforation.

vealed diffuse rhonchi and wheezing to auscultation. The liver and spleen were not enlarged.

An x-ray of the chest was normal. A barium swallow revealed a large, constricting, irregular thoracic esophageal lesion measuring 10 cm in length (Figure 1). After premedication with meperidine 50 mg IV, atropine 0.5 mg IM, and diazepam 5 mg IV, an Olympus GIF-P2 gastroscope was passed under direct vision to the level of the stricture. The lumen was only 5 to 6 mm in diameter. Under fluoroscopic control, a guide wire was passed through the stricture and positioned in the stomach, and serial dilatations were carried out with the Eder-Puestow dilators. In spite of considerable mechanical resistance, dilatation was continued to a 35 F size. This immediately was followed by esophagogastroduodenoscopy which demonstrated a circumferential irregular elongated 12 cm lesion. The esophagogastric junction, stomach, and duodenum were normal. Biopsy, brush cytology, and washings were done and all were positive for squamous cell carcinoma. After 24 hours rest, the dilatation to a 50 F size was carried out and a Key-Med Atkinson esophageal prosthesis was placed with ease, perorally, under direct endoscopic view and with the aid of a pusher tube. Repeat barium swallow, performed immediately after the procedure, demonstrated that the prosthesis was in perfect position, without leakage or perforation (Figure 2). The patient was placed on a blenderized diet. No dysphagia occurred. Washing down with water was occasionally required. The patient was particularly pleased with the return of normal swallowing.

Further investigation included liver/spleen scan and bone scans that were normal. CT scan of the chest demonstrated local lymph node involvement.

The patient's clinical condition improved rapidly; she gained weight and a few days later was referred for radiotherapy as an outpatient.

DISCUSSION

A definite cure of esophageal cancer lies only in its prevention and early detection,[1,4,6,7] both of which, unfortunately, are very rarely possible. By the time the patient seeks medical advice, the disease already is widespread and nonresectable.[1-6] Therefore, in this situation, palliation re-



Figure 3—The pusher tube and Key-Med Atkinson endoprosthesis are assembled on an Olympus GIF-P2 gastroscope ready for insertion.

mains the only achievable goal.[4,6] Although surgery frequently is used for this purpose, it rarely is a successful option in the management of terminal esophageal cancer.[4-6] The success of surgical palliation will depend on the location and the size of the esophageal cancer.[4,6,8,12,13] Lower esophageal lesions offer the best chance for surgical palliation. The classification and staging of esophageal cancers have been slow to evolve. CT scanning can contribute significantly to the staging and selection of the best potential surgical candidates.[4,6,8,12,13] In general, one may state that the smaller the lesion, the better the chance of survival. In one series, 66 percent of the patients with lesions smaller than 5 cm survived more than one year.[14]

Radiotherapy temporarily may alleviate dysphagia, but an unobstructed esophageal lumen may be difficult to maintain with radiotherapy alone.[4,7] Furthermore, because of initial edema secondary to radiotherapy, complete obstruction of esophageal lumen may be unavoidable. Therefore, no patient with carcinoma of the esophagus should have radiotherapy without adequate dilatation and/or insertion of esophageal prosthesis.[3,4,6]

Conventional chemotherapeutic agents have limited value,[1,3] but newer investigational drugs appear to be substantially more effective.[5] Trials of endoscopic palliative therapy with laser, for obstructing esophageal carcinomas, have been tried successfully but they are in an experimental stage.[15]

Feeding gastrostomy leaves the patient with a miserable existence for the rest of his or her life. Marked sialorrhea, with associated aspiration, continues unabated.

DILATATION AND ESOPHAGEAL PROSTHESIS

Thus, it seems clear that the best palliative method, which is the easiest, safest, and quickest for the nonresectable carcinoma of the esophagus, is peroral dilatation and insertion of an esophageal prosthesis,[4,6,9,11] with or without radiotherapy. Pull-through esophageal endoprosthesis requires another surgical intervention and carries a significant morbidity and mortality for a palliative procedure.[15] Therefore, it should be replaced by push-through peroral esophageal endoprosthesis.

The peroral esophageal endoprosthesis can be placed anywhere in the esophagus except above and in the immediate vicinity of the crycopharyngeal muscle, because of foreign body sensation and dangerous pressure effect on the adjacent organs.[5,6] It provides an effective means of palliation in all malignant esophageal obstructions, due to esophageal carcinomas and to gastric and pulmonary carcinomas involving the esophagus.[3,4,6,8,9,11,12] Esophageal endoprosthesis especially is indicated in bronchoesophageal fistulae.[9,12] It is contraindicted in benign esophageal strictures.[6]

Before any attempt is made to insert the esophageal prosthesis, the location, configuration, and length of the tumor must be determined accurately and a tissue diagnosis must be obtained. Barium swallow, especially endoscopic measurements and biopsy, washings, and brush cytology are most important for diagnosis and evaluation. Not only the length of the tumor, but also the distance between the teeth and proximal end (shelf) of the tumor and the proximity of the distal end of the tumor to the cardia should be recorded carefully. These measurements are extremely important in tailoring a prosthetic device or selecting a commercially available one to fit the patient's particular need. Precise measurements also are mandatory for proper placement of the device within the esophagus.

According to the method precisely described by Palmer and Boyce,[17] a prosthetic device can be tailored easily to the patient's need, from inexpensive polyvinyl tubing. At the same time, a pusher tube measuring 45 cm in length can be prepared. The distance between the teeth and the proximal shelf of the tumor should be marked on the distal end of the pusher tube. This mark will indicate how far the prosthesis should be pushed into the esophagus. The length of the prosthesis should be 2 to 3 cm longer than the length of the tumor so that tumor overgrowth will not cause obstruction of the prosthesis.

The malignant stricture should be dilated to at least 45 F luminal diameter before a prosthesis is inserted. The pace and intervals between dilatations depend on the patient's tolerance, the distensibility of malignant stricture, and the development of complications such as perforation, copious bleeding, or aspiration pneumonia.

"Before any attempt is made to insert the esophageal prosthesis, the location, configuration, and length of the tumor must be determined accurately and a tissue diagnosis must be obtained."

If there is no marked tortuosity in the malignant stricture or bronchoesophageal fistula, larger diameter dilatations (35 F and over) may be carried out without a guide wire and with Hurst's or Maloney's mercury bougies.

The endoscope itself, the shaft of the Eder-Puestow dilator, or a large size (45 F) Hurst's bougie can be used as guide shaft on which the esophageal prosthesis and the pusher tube can be assembled (Figure 3). After liberal lubrication, including the inside and the outside of the prosthesis as well as the pusher tube, the whole assembly can be passed perorally, as if performing an esophagoscopy with a large-size endoscope. Patients usually tolerate this end-stage procedure surprisingly well.

We prefer using the gastroscope as a guiding shaft because it enables us to examine the position of the prosthesis in place, to detect any complication that might have developed, and finally by bending the tip of the scope, the whole assembly can be pulled back, if necessary. The prosthesis also

can be withdrawn by using a grasping forceps or a polypectomy snare.

After the endoprosthesis is seated properly, the pusher tube is first twisted clockwise so that it can disengage from the prosthesis; then, it is gently pulled back with the scope, while the prosthesis in place is observed for any sign of complication. This is followed by a chest x-ray and later a barium swallow, to check once more the position of the prosthesis and to look for any sign of a complication.

Complications related to the procedure, in a series of 200 patients, are reported as follows:[6,10] bleeding, 1.5 percent; perforation, 8 percent; pressure necrosis, 4 percent; migration of the prosthesis, 17 percent; and obstruction of the prosthesis by tumor overgrowth, 22 percent. In our series of five patients, we have not seen any significant bleeding. There has been one perforation and frequent obstruction of endoprosthesis by food which was dislodged easily by a small Hurst bougie or by the endoscope itself. When the patients were taught to wash down the food with water, this complication was reduced significantly. We did not see any obstruction due to tumor overgrowth, probably because we always used radiotherapy as an adjunct to endoprosthesis. Migration of the endoprosthesis can be prevented by adding a distal retaining flange to it (Figure 3).

CONCLUSION

Although carcinoma of the esophagus is a progressive, debilitating, and fatal disease, peroral dilatation and endoprosthesis, with or without radiotherapy, can provide adequate palliation in the great majority of patients. Life is not prolonged, but its quality is dramatically improved. Endoprosthesis immediately relieves the dysphagia and sialorrhea, prevents aspiration pneumonia, and gives the patient a chance and satisfaction to resume normal eating and nutrition. It also allows the patient to spend as much time as possible out of the hospital, in the comfort of his or her home.

REFERENCES

1. Rorenberg JC, Schwade JG, Vaitkevicius VK: Cancer of th esophagus, in DeVito VT, Hellman S, Rosenberg, SA (eds): *Cance Principal and Practice of Oncology*. Philadelphia, PA, Lippincot 1982, pp. 499-533.
2. Lowe WC: Survival with carcinoma of the esophagus. *An Intern Med* 77:915-918, 1972.
3. Boyce HW Jr: Medical management of esophageal obstructio and esophageal-pulmonary fistula. *Cancer* 50:2597-2600, 1982.
4. Boyce HW Jr: Approaches to management of cancer of th esophagus. *Hosp Prac* 17:108-124, 1982.
5. Kelsen D: Treatment of advanced esophageal cancer. *Cance* 50:2576-2581, 1982.
6. Sivak MV Jr: Therapeutic endoscopy of the esophagus.*Sur Clin North Am* 62:807-820, 1982.
7. Skinner DB, Dowlatshahi KD, DeMeester JR: Potentiall curable cancer of the esophagus. *Cancer* 50:2571-2575, 1982.
8. Howard M, McCallum RW: A modified technique for perora placement of an esophageal prosthesis. *Gastrointest Endos* 62:805-820, 1982.
9. den Hartog Jager FC, Bartelsman JF, Ttytgat GN: Palliative treatment of obstructing esophagogastric malignancy by endoscopic positioning of a plastic prosthesis. *Gastroenterology* 77:1008-1014, 1979.
10. Adams CL: The complications of endoesophageal tubes. *J Thorac Surg* 51:685-693, 1966.
11. Palmer ED: Peroral prosthesis for the management of incurable esophageal carcinoma. *Am J Gastroenterol* 59:487-498, 1973.
12. Moss AA, Schynyder P, Ruedi FT, et al.: Esophageal carcinoma: Pretherapy staging by computed tomography. *AJR* 136:1051-1056, 1982.
13. Bralow SP: Diagnosis and staging of esophageal and gastric cancer. *Cancer* 50:2566-2570, 1982.
14. Goodner JT: Surgical principles of resection and reconstruction, in Rubin P (ed): *Cancer of the Gastrointestinal Tract*. American Cancer Society, Inc. New York, NY, 1974, pp. 17-19.
15. Fleischer D: The current status of gastrointestinal laser activity in the United States. *Gastrointest Endosc* 28:157-161, 1982.
16. Girardet RE, Ransdel HT, Wheat MW: Palliative intubation in the management of esophageal carcinoma. *Ann Thor Surg* 18:417-430, 1974.
17. Boyce HW Jr. Palmer ED: Instruments for esophageal dilatation, in Boyce HW Jr, Palmer ED (eds): *Techniques of Clinical Gastroenterology*. Springfield, IL, Charles C. Thomas, 1975, pp. 226-236.

Acute Radiation Pneumonitis

STUART SILBERSTEIN, M.D., DANIEL MALCOLM, M.D.,
VALYNNE V. BRAUN, M.D., A. OLUSEGUN FAYEMI, M.D., Teaneck*

A patient with lymphosarcoma and pleural effusion was treated with chemotherapy and radiation therapy to the affected lung. Clinical remission resulted and the chest x-ray became normal. One week later, she developed an asymptomatic interstitial pulmonary infiltrate, which biopsy proved to be acute radiation pneumonitis. This case illustrates an abrupt onset of acute radiation pneumonitis without dyspnea, cough, or fever and demonstrates that the radiologic distinction between acute and chronic radiation changes is not absolute.

The appearance of a new chest roentgenographic infiltrate in an immunocompromised host presents a perplexing problem to the clinician. In the case of a patient with a lymphoma who has received both chemotherapy and radiotherapy, the differential diagnosis consists of extension of the malignancy, opportunistic infection, and toxicity of therapeutic agents. The appearance, location, distribution, and time of appearance of the infiltrate are important features leading to the correct diagnosis, especially in radiation-induced lung disease. We report a case of radiation pneumonitis that emphasizes how abruptly and atypically this entity can appear.

CASE REPORT

A 56-year-old white woman with lymphosarcoma diagnosed by cervical lymph node and parotid gland biopsies in 1976 was treated with cyclical courses of cyclophosphamide, vincristine, and prednisone. She did well until February 1981, when she developed dyspnea and a left chylous pleural effusion. CAT scan revealed mediastinal lymphadenopathy; a left pleural biopsy showed involvement by lymphosarcoma. She then was treated with vinblastine and bleomycin; a total dose of 150 mg of the latter was administered by continuous infusion over ten days. There was no response to this therapy; she subsequently was given radiotherapy consisting of 4,500 rads to the mediastinum over five weeks. At the completion of the radiotherapy, there still was a large left pleural effusion. In April 1981, she was treated with cyclical courses of carmustine, procarbazine, and prednisone. Lymphadenopathy and pleural effusion resolved, and a chest roentgenogram on October 10, 1981, was normal (Figure 1). One week later, she developed pancytopenia and a chest roentgenogram revealed a left upper lobe streaky interstitial infiltrate (Figure 2). She had no cough, dyspnea, or fever; physical examination of the lungs was normal. Gram stain of sputum revealed few polymorphonuclear leukocytes but no organisms. Sputum culture grew normal flora only; blood and urine cultures were sterile. There was no evidence of recurrence of the lymphosarcoma. She underwent fiberoptic bronchoscopy and transbronchial lung biopsy of the involved portion of the lung under fluoroscopic guidance. The bronchial mucosa appeared grossly normal.

*From Holy Name Hospital where Dr. Silberstein is Attending, Department of Pulmonary Medicine; Dr. Malcolm is Director, Division of Medicine; Dr. Braun is Attending Pathologist; and Dr. Fayemi is Attending Pathologist. Correspondence may be addressed to Dr. Silberstein, 133 Engle Street, Englewood, NJ 07631.



Figure 1—Normal anterior-posterior view of chest.



Figure 2—Anterior-posterior view of chest taken one week later, demonstrating streaky interstitial infiltrate in left upper lobe.

PATHOLOGY

Microscopically, the lung parenchyma showed thickening of the alveolar septa by edema, fibrosis, and mild mononuclear inflammatory infiltrate. Hyaline membranes partially lined the wall of occasional alveoli. Hyperplasia of alveolar lining cells with large bizarre hyperchromatic nuclei and foamy cytoplasm also was observed (Figure 3). Some blood vessels showed myointimal proliferation; rare foamy cells in the intima were seen (Figure 4). Cytologic changes similar to those seen in the alveolar lining also were observed on the bronchial epithelium. These histopathologic alterations are characteristic of acute radiation pneumonitis.[9]

DISCUSSION

Radiation-induced lung disease can take the form of acute radiation pneumonitis or late-onset radiation fibrosis. The statistics are varied as to the incidence, but Gross estimates that 10 to 15 percent of patients receiving radiotherapy to the lungs develop clinically appreciated, radiation-induced lung disease.[1] Acute radiation pneumonitis usually ensues two to three months following completion of therapy; the range, however, can extend from two weeks to greater than six months. The most common symptoms are dyspnea, cough, and fever which can be high and spiking. The physical examination usually is unremarkable but tachypnea, cyanosis, and evidence of pulmonary consolidation may be observed. The earliest roentgenographic feature observed rarely consists of an area of radiolucency.[2] More common is a ground-glass haze with sharp borders corresponding to the port of the radiotherapy. An air bronchogram may be



Figure 3—Lung biopsy showing thickening of alveolar septa by edema, fibrosis, and mononuclear inflammatory cells. Enlarged alveolar lining cells (cuboidal and polygonal) are present. Hyaline membrane (arrows) partially lines the wall of an occasional alveolus.

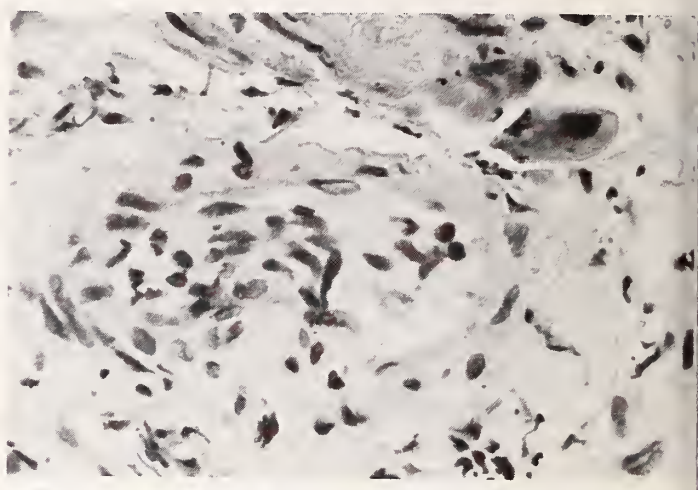


Figure 4—Artery showing myointimal proliferation with rare foam cells. Bizarre large alveolar cells are seen at upper right-hand corner.

visualized and alveolar and nodular infiltrates are observed, albeit infrequently. Pleural effusion, when present, usually is small and once established does not increase.

The majority of patients with radiation pneumonitis become asymptomatic over a period of months; however, nearly all will develop roentgenographic evidence of pulmonary fibrosis in the area of the previous pneumonitis. While the time course is variable, roentgenographic changes from pneumonitis to fibrosis progress over a period of six months to one year. An occasional patient, however, will show interstitial fibrosis without preceding symptoms of radiation pneumonitis.[3] The majority of patients with interstitial fibrosis are asymptomatic, though a few will have extensive disease leading to chronic respiratory failure and cor pulmonale.[4] Once established, the roentgenographic changes are permanent.

Factors known to increase the likelihood of radiation pneumonitis are large radiation dose, short course of therapy, treatment of a large volume of lung,[5] previous radiation therapy,[6] concurrent chemotherapy,[7] and steroid withdrawal.[8] One can speculate that the antecedent therapy with bleomycin played a role in determining the speed and nature of this patient's roentgenographic changes. However, not only was the dose of bleomycin not large, but more than six months elapsed between the bleomycin therapy and radiation and the subsequent evolution of atypical pulmonary

infiltrate. Hence, synergism between bleomycin and radiation most probably would not explain the occurrence of the atypical presentation.

CONCLUSION

This case demonstrates how abruptly the changes of radiation pneumonitis can develop. We were fortunate to have had a chest x-ray that was normal one week prior to the abnormal x-ray. The radiologic change exhibited was an interstitial change usually interpreted as chronic radiation fibrosis; lung biopsy, however, demonstrated changes of acute radiation pneumonitis.

One can conclude that the radiologic distinction between the acute and chronic radiation changes is not absolute. The presence, then, of rapid development of a streaky interstitial infiltrate should not preclude the diagnosis of radiation-induced lung disease.

REFERENCES

1. Gross MJ: Pulmonary effects of radiation therapy. *Ann Intern Med* 86:81-82, 1977.
2. Warren S, Spencer J: Radiation reaction in the lung. *Am J Roentgenol* 43:682-701, 1940.
3. Lipshitz HZ, Southard ME: Complications of radiation therapy: The thorax. *Semin Roentgenol* 9:41-49, 1974.

Fried JR, Goldberg H: Postirradiation changes in the lung and thorax. *Am J Roentgenol* 43:877-895, 1940.

5. Evans WA, Leucutia T: Intrathoracic changes induced by heavy radiation. *Am J Roentgenol* 13:203-220, 1925.
6. Brady LW, Germon PA, Caudler L: The effects of radiation therapy on pulmonary function in carcinoma of the lung. *Radiology* 85:130-134, 1965.
7. Phillips TL, Wharam MD, Margolis LW: Modification of radiation injury to normal tissues by chemotherapeutic agents. *Cancer* 35:1678-1684, 1975.
8. Castellino RA, Glatstein E, Turbow MM, et al.: Latent radiation injury of lungs or heart activated by steroid withdrawal. *Ann Intern Med* 80:593-599, 1974.
9. Fajardo LF, Berthrong M: Radiation injury in surgical pathology, a review article. *Am J Surg Pathol* 2:159-199, 1978.

Are you faced with DIVORCE?



Do you know how EQUITABLE DISTRIBUTION in New Jersey affects you?

Trial Attorneys of New Jersey
invites you to attend its seminar:

"Valuing the Professional Entity in Divorce Litigation"

Saturday • January 21,1984
9 a.m. - 3:30 p.m. • Scanticon-Princeton

Tuition: $125.
Send check with name, address, phone number to:

TANJ
Box 148
Boonton, N.J. 07005

Questions? Call 201-263-8025

Doctors: Write your own prescription to cure insurance pains . . .

Rx Prescription

Name MSNJ Member

MSNJ Group Blue Cross/Blue Shield Major Medical and Dental Insurance

that provides:

- **Flexible plans**
- **Comprehensive benefits**
- **Low, competitive rates**
- **Centralized Administration**

Designed and Administered by
DONALD F. SMITH & ASSOCIATES

Rx Prescription

Name _____

Address _____

Phone _____

Please send more information on the MSNJ

- ☐ Blue Cross/Blue Shield Program
- ☐ Major Medical Program
- ☐ Group Dental Program

Return to:
Donald F. Smith & Associates
One Airport Place, Route 206 North
P.O. Box 2197,
Princeton, New Jersey 08540
(609) 924-8700, (201) 622-6046

Autopsies at Newark City Hospital, 1908 to 1911

WILLIAM D. SHARPE, M.D., South Orange*

Despite considerable real poverty, between 1908 and 1911, Newark was a much safer and less violent place to live than now, based on a review of autopsies at Newark City Hospital.

During the decade before the first World War, Newark—the largest city in New Jersey—was a prosperous industrial and trading center with a population, for Health Department purposes, of about 348,000. In 1910, its death rate was 16.64/1,000 and its city death rate "excluding hospital mortality" was 12.12/1,000.[1] It was a blue collar town with strong ethnic traditions; it was not greatly different from the other industrial cities of a prosperous Northeast. Newark had a distinguished medical community, some of whom had international reputations.

Newark City Hospital was founded in 1883, and the main building—four stories with basement, of red brick—was built in 1899 at a cost of $450,000. From 1908 to 1911, it had approximately 250 beds and, for the time, was a large hospital. Twelve interns, beginning their two-year terms at staggered three-month intervals, cared for their patients under the supervision of a voluntary and wholly unpaid attending staff drawn from the best physicians and surgeons in the community. Newark had other hospitals at that time: Saint Michael's, Babies, Saint Barnabas, Saint James, German Hospital, Women and Children, Eye and Ear, and Beth Israel. Some of these survived, others have merged or fled to the suburbs. There also were a variety of refuges, almshouses, private sanatoria, and private hospitals, some of them little more than a private residence with an operating room for the use of a single surgeon. In 1910, 1,558 deaths occurred in Newark hospitals and kindred institutions: 625 were in Newark City Hospital (40 percent of the total) and 799 in the other eight hospitals listed (51 percent of the total number of hospital deaths). We may conclude that these smaller institutions played a very minor role in Newark's 1910 medical care scene.[1]

In 1910, typical of the years with which we are concerned, part-time physicians employed by the City Health Department sent 1,879 patients to Newark hospitals, 592 of them to the Newark City Hospital; 32 percent of those sent to the hospital by city physicians consulted by patients who did not have their own private physicians. The rest of the breakdown is as follows: 45 (2 percent), Hospital for Women and Children; 23 (1 percent), Home for Crippled Children; 270 (14 percent), Eye and Ear Infirmary; 277 (15 percent), Babies Hospital; 160 (9 percent), Newark Tuberculosis Sanatorium; 128 (7 percent), Saint Michael's Hospital; 93 (5 percent), Saint Barnabas Hospital; 87 (5 percent), Saint James Hospital; 98 (5 percent), German Hospital (now Clara Maass); and 106 (6 percent), Beth Israel.

Of the 1,104 patients sent by city physicians to general hospitals, 592 (59%) went to Newark City Hospital. This was an adequate sample and sufficient evidence that City Hospital then as now was the main source of hospital care for the medically indigent.[1]

I will review the autopsies performed by Dr. Harrison Martland between October 1908, and the end of 1911 to describe the patterns of disease at that hospital at that time to learn about the urban poor Newark City Hospital served. Harrison Stanford Martland was born in Newark in 1883; he graduated from Western Maryland College in 1901 and from the College of Physicians and Surgeons of Columbia University in 1905. Dr. Martland spend 18 months as an intern at the New York City Hospital, then on Blackwell's Island in the East River, and for a year was assistant pathologist at the Russell Sage Institute, New York. In the fall of 1908, he was appointed pathologist to Newark City Hospital. Until 1920, he had no secretary. He spent his professional life at Newark City Hospital, lived at 180 Clinton Avenue, retired after a cerebrovascular accident in 1952, and died in 1954.[2] This report is based on the first-bound volume of Martland's autopsy protocols in the archives, UMDNJ, Newark; others

*A portion of this paper was read at a meeting of the Medical History Society of New Jersey, October 20, 1982, and at the Section on Medical History, New York Academy of Medicine, May 25, 1983. Correspondence may be addressed to Dr. Sharpe, 62 University Court, South Orange, NJ 07079.

TABLE 1

Newark City Hospital Autopsy Outline, 1908-1911

Pathological Laboratory of the Newark City Hospital

History No. ..... Autopsy No. .....
Name ..... Age..... Source .....
Date of Death ..... Date of Autopsy .....

Diagnosis Anatomica

Cerebrum
Medulla spinalis
Cor
Pulmo (Sinistra
(Dextra
Lien
Glandula Sinistra
Suprarenalis dextra
Ren (Sinistrum
(Dextrum
Duodenum
Ventriculus
Pancreas
Hepar
Intestinum tenuum
Intestinum crassum
Tractus genito-urinarius
Systemum lymphaticum
Telae serosae
Os et larynx
Abnormalitates anatomicae
Laesiones alterae
Causa mortis

Path .....

in the series, and the contemporaneous patient records, have perished.

THE PROTOCOLS

The autopsy protocols themselves are extremely terse, and sometimes provide only the patient's surname and a few words of description. A Latin outline was printed, the *diagnosis anatomica,* on a good grade of 16-pound bond paper measuring 10½ by 14 inches. These were completed, very sketchily, by entering a diagnosis rather than a description or organ weights, in ink, speared on a spindle file, and eventually collected into heavy canvas-bound folios about 3 inches thick. Martland started by describing his findings in Latin, but soon gave this up and wisely reverted to English. Table 1 illustrates the format.

The protocols are numbered consecutively from 1 (4 October 1908) through 576 (29 December 1911) but, as Table 2 shows, 1 protocol was interpolated, 13 are missing, and 26 are blank—an accession number and perhaps a name are provided, but nothing more; hence, our analysis will be based on 537 protocols. Most of these are extremely brief, but 25 of the printed sheets are accompanied by quite full gross descriptions of which the printed *diagnoses anatomicae* provide accurate summaries. We do not know whether these 25 were exceptions, or whether full descriptions were prepared for all of the autopsies but have been lost. Almost no clinical information is provided, and there are neither microscopic descriptions nor epicrises. Most data are entered in longhand. Martland performed all but 2 (478 and 481) of this series, the 2 being done by a Dr. McKenzie during the third week of June 1911 when Martland was apparently on

TABLE 2

Newark City Hospital Autopsy Study, 1908-1911: Statistical Base (537 cases available for analysis)

Year	1908	1909	1910	1911
Opening accession number	1	37	201	387
Closing accession number	36	200	386	576
Protocols missing from book	0	5	6	2
Protocol present but blank	0	2	19	5
Interpolated protocol (i.e. 307½)	0	0	1	0
Total autopsies for the year	36	164	186	190
Blank and missing protocols	0	7	24	7
Available for analysis	36	157	161	183

vacation. Sometimes, ten days elapsed between autopsies, and sometimes Martland did 4 in one day. Surviving complete protocols suggest that he usually spent about an hour and a half on a discussion, about the same time an experienced autopsy surgeon still requires.

DO THESE AUTOPSIES REPRESENT THE HOSPITAL POPULATION?

Martland usually recorded the number of deaths and the number of autopsies performed during each month, and we have this information for 33 of the 39 months under review. The monthly autopsy percentage, that is, the percent of deaths in hospital in which autopsies were done, ranged from a low of 14 percent in September 1909 to a high of 35 percent in April 1909. For these 33 months, the mean monthly autopsy rate was 25.5 percent, the median, 25 percent, and the mode, 27 percent. The median monthly autopsy rate varied little from year to year: in 1909, 27 percent; in 1910, 27 percent; and in 1911, 25 percent. Most pathologists would consider this an adequate sampling of Newark City Hospital deaths, but only just adequate, although it is a higher autopsy rate than now obtained in many teaching hospitals.

It is axiomatic that every patient buried without an autopsy died of a correctly diagnosed, correctly treated disease without undiagnosed complications. It also is customary that clinicians, particularly those who really are not interested in taking care of sick people, react to unwelcome autopsy reviews by an attack on the statistical base of the study. Hence it also is axiomatic that every autopsy series reports atypical events. Granting that 537 autopsies is not a sufficiently large number of autopsies to manipulate very vigorously, Table 3 shows that our series comes from the same population as the whole number of deaths in the United States and in Newark during 1910 so far as can be recalculated from the somewhat idiosyncratic nosologic classification used by the Newark health department at that time.

There are some difficulties. Autopsy diagnoses, for quite complicated reasons, may describe a somewhat different population than that described by death certificates, and death certificates notoriously are inaccurate. Syphilis, then as now, often is underreported as a cause of death, with or without autopsy. Newark had good drains and, until World War II, an outstanding health department, so that typhoid and the other enteric fevers were less frequent in Newark than, for example, in New Orleans. Childhood diseases usually were treated at home or in special children's hospitals. Whatever it was that physicians in 1910 termed "gastritis, duodenitis, enteritis, and colitis" now is beyond conjecture, but very likely it included such dissimilar entities

TABLE 3

Some Common Causes of Death: Newark, United States (1910), and Newark City Hospital Autopsies, 1908-1911

	Deaths/100,000/Year			
	U.S.* 1910	Newark# 1910	U.S.* 1970	This Series
Tuberculosis, all forms	153.8	233	2.6	84
Syphilis, excl. aortic aneurysm	13.5	3	0.2	5
Typhoid, paratyphoid fevers	22.5	12	†	7
Scarlet fever, strep. throat	11.4	11	†	0
Diphtheria	21.1	29	†	4
Whooping cough	11.6	13	†	0
Measles	12.4	9	†	0
Malignant neoplasms, incl. hemolymphatic	76.2	86	162.8	30
Diabetes mellitus	15.3	17	18.9	2
Major cardiovascular-renal	371.9	313	496.0	77
Influenza, pneumonia, excl. newborn	155.9	211	30.9	41
Gastritis, duodenitis, enteritis, colitis	115.4	20	0.6	7
Cirrhosis	13.3	20	15.5	8
Motor vehicle accidents	1.8	—	26.9	7
Accidental falls	15.4	—	8.3	10
Other accidents, incl. homicides	67.0	23	21.2	79
Suicide	15.3	21	11.6	18
Total, excluding fetal	**1,470.0**	**1,664**	**950.0**	**379**

*U.S. 1910 and 1970 death rates from United States Department of Commerce, *Historical Statistics of the United States, Colonial Times to 1970.* Washington, D.C., 1975, vol. 1, pp. 49-64.

#Newark 1910 death rates have been calculated as a reasonable approximation from *Annual Report of the Department of Public Health, City of Newark, NJ, for the year 1910,* pp. 100-107, and assumes a population of 348,000.

†Fewer than 0.5.

TABLE 4

Ages at Death, Newark City Hospital Autopsies, 1908-1911

	Number	Median	Mode(s)
Adults			
Gender not stated	318	41 yr	35, 40 yr
Men	47	42 yr	42, 45 yr
Women	48	33 yr	30, 32 yr
Total adults	413	40 yr	22 yr
Children (below 10 years)*			
Gender not stated	62	6½ mo	1 mo
Boys	5	2½ mo	—
Girls	1	4 yr	—
Total children	68	7 mo	1 mo, 1 yr

*Excluding 17 stillbirths and 9 "newborns."

as acute myocardial infarction, perforated duodenal ulcer, and carcinoma of the colon. City hospitals, then as now, attract more than their share of accident victims. Overall, this 1908 to 1911 autopsy series is fairly, if not completely, representative of the world of disease as it was defined in 1910. The patient population is weighted toward low-income groups who, when they fell ill, were attended by physicians who were paid by the city rather than by private physicians.

HOW LONG DID THE PATIENTS LIVE?

The patient's age not always is given in these protocols, and a scatter plot of patients' ages at death yields the usual concentrations of deaths at 30, 35, 40, 45, 50, and 55 years that suggests that these ages often were estimated. The median age at death was 40 years (Table 4). Among the small sample of men and women, the ages at death were 42 and 33, respectively; the latter was partially but not entirely due to the hazards of childbirth. It is when we turn to the children that we see how uncertain the first year of life really was even so late as 1910. The median age of death among children, here defined as the completion of fewer than 10 years, was seven months, with modes of 1 year and one month. Most children died at home, or in one of the children's hospitals in Newark.

This relative youth at death—a median of 40 years for the whole series—should be reviewed in the light of age-cohort death rates for 1910 (Table 5). In 1910, death rates began to double at 55 to 64 years, and in 1970, 65 to 74 years. But among our population, the greatest number of deaths occurred during the decade 35 to 44 years, and more died at 25 to 34 and 45 to 54 than at 55 to 64 years. In 1908 to 1911, Newark City Hospital was not a place where old people came

or were abandoned to die. It was a place where young people, many with young families, died early during what should have been their most productive years.

OF WHAT DID THEY DIE?

Neither neonatal nor pregnancy-related deaths in this series reflect the whole Newark experience because in 1908 to 1911, as in most parts of the United States, most confinements took place at home.

Neonatal deaths at Newark City Hospital in 1908 to 1911 came from a population that did not give birth at home (Table 6). We suspect that high-risk or complicated deliveries were admitted or transferred to the hospital only after difficulties beyond the physician's or midwife's capacity were encountered, and that many mothers in advanced complicated labor arrived in the hospital too late for cesarean section. This may be the best explanation for the number of deaths attributed to traumatic or prolonged labor (6) and to placental or cord problems (5)—a total of 11 out of the 38 neonatal deaths and stillbirths. Since neonatal intensive care units were unknown until primitive incubators were introduced after World War I, deaths from prematurity (7), atelectasis neonatorum (5), and asphyxia (1) were more frequent than now. Central nervous system anomalies claimed 4 lives, and we cannot explain this incidence, which does seem unusually high. Three were merely stillborn, and 3 had fatal congenital syphilis. What was meant by infantile nonrenal anasarca is not clear; perhaps it was hydrops fetalis.

Pregnancy-related deaths in this series probably do not reflect the whole community's experience. Other specialized hospitals existed, most babies were born at home, and one is not sure what percentage of mothers were hospitalized (Table 7). Obstetric complications can be abrupt, unanticipated, and without blood replacement and immediate access to an operating room, rapidly fatal. Hemorrhage and placenta previa claimed four mothers, and puerperal sepsis killed five mothers. We do not know whether these five women developed their sepsis at home and were admitted to the hospital, or whether they were delivered and infected in the hospital. Neither eclampsia nor renal complications of pregnancy are without risk today.

Abortion, then illegal, claimed lives. Three women died of postabortal sepsis, one of sudden air embolization while a midwife was inducing abortion using a catheter, one developed peritonitis from a perforated uterus, and two died from drugs taken to induce abortion. The youngest woman who died of the effects of abortion was 20 years old and the oldest was 27. Abortion then was a criminal offense but was not a problem among teen-aged girls; neither knitting needles nor coat hangers are mentioned in these autopsy protocols.

Pediatric deaths in this series are difficult to interpret; many of the children who died when younger than ten years old have been grouped among the infections (Table 8). Even excluding those who died of diagnosed infections and the two who died of malignant neoplasms, the results make grim

TABLE 5

Death Rates by Cohorts, U.S. 1910 and 1970, v Newark City Hospital Autopsies, 1908-1911

	Deaths/100,000/Year*		Newark City Hospital
	1910	1970	Autopsies
Total	14.7	9.5	499**
Under 1 Year	131.8	21.4	51***
1 to 4 Years	14.0	0.8	19
5 to 14 Years	2.9	0.4	16
15 to 24 Years	4.5	1.3	42
25 to 34 Years	6.5	1.6	84
35 to 44 Years	9.0	3.1	109
45 to 54 Years	13.7	7.3	81
55 to 64 Years	26.2	16.6	61
65 to 74 Years	55.6	35.8	28
75 to 84 Years	122.2	80.0	8
85 Years and older	250.3	163.4	0

*Excluding fetal deaths, from United States Department of Commerce, *Historical Statistics of the United States, Colonial Times to 1970.* Washington, D.C., 1975, vol. 1, pp. 49-64. Addendum: Distribution of ages at death from the 1910 Newark City Health Department report (p. 99) cannot be compared, but from the population of 348,000 were as follows: Under one year 1,242; 1 to 2 years, 278; 2 to 5 years 258; 5 to 20 years 357; 20 to 60 years 2,350; and over 60 years 1,299 deaths.

**Autopsy series excludes stillbirths.

***Ages are not stated in 32 records, and 17 protocols are of stillbirths.

TABLE 6

Newark City Hospital Autopsies, 1908-1911: Neonatal Deaths

Cause	Number	Median Age (years)	Range
Prematurity	7	15 days	2 to 30 days
Traumatic or prolonged labor	6	SB	SB to 12 days
Atelectasis neonatorum	5	SB	SB to 1 day
Congenital anomalies:			
Central nervous system	4	SB	SB to 1 day
Heart	2	3 mo	1 day; 6 mo
Multiple	1	8 days	
Stillborn	3	SB	
Maternal placenta previa or hemorrhage	3	SB	SB to 1 day
Congenital syphilis	3	1 wk	SB to 7 mo
Asphyxia	1	1 day	
Premature separation of placenta	1	SB	
Prolapsed cord	1	SB	
Infantile nonrenal anasarca	1	6 wk	

SB = Stillborn

TABLE 7

Newark City Hospital Autopsies, 1908-1911: Pregnancy-Related Deaths

Cause	Number	Median Age (years)	Range
Puerperal sepsis	5	30	26 to 32
Postabortal sepsis	3	25	21 to 26
Eclampsia	2	22.5	17 to 28
Postpartum hemorrhage	2	38	36 to 40
Postpartum renal failure	1	34	
Postpartum anemia	1	24	
Postpartum nephritis	1	31	
Placenta previa	1	22	
Postabortal peritonitis	1	27	
Postabortal air embolism	1	20	
Postabortal gastrointestinal hemorrhage (took unknown drug to induce abortion)	1	—	
Mercury bichloride poisoning (used as abortifacient)	1	22	

TABLE 8

Newark City Hospital Autopsies, 1908-1911: Pediatric Deaths

Cause	Number	Median Age (years)	Range
Malnutrition	4	6 mo	3 to 12 mo
Marasmus	3	60 days	40 to 120 days
Congenital herniation of cecum into duodenojejunal fossa	1	6 yrs	
Intussusception	1	13 mo	
Acute enterocolitis	1	1 yr	
Empyema	1	16 mo	
Aspiration of vomit	1	8 days	
Exposure, asphyxia	1	2 mo	
Exposure	1	10 mo	
Hydrocephalus	1	18 mo	
Sepsis	1	10 days	
Gastroenteritis	1	6 mo	
Streptococcal peritonitis	1	11 mo	

TABLE 9

Newark City Hospital Autopsies, 1908-1911: Cardiovascular Deaths

Cause	Number	Median Age (years)	Range
Bacterial endocarditis	5	27	11 mo to 48 yr
Mitral stenosis	5	40	20 to 66
Myocarditis	5	55	35 to 65
Aortic regurgitation	4	48.5	40 to 52
Rheumatic bacterial endocarditis	2	47.5	42 to 53
Chronic aortic endocarditis	2	49.5	42 to 57
Mitral insufficiency	2	42	32 to 52
Patent foramen ovale	1	42	
Syphilitic heart disease	1	35	
Combined aortic and mitral stenosis	1	31	
Coronary thrombosis	1	47	
Hypertrophied dilated heart with fatty degeneration of coronary arteries	1	62	
Myocarditis with atheromatous coronary arteries	1	50	
Cardionephritis	1	21	
Pulmonary embolus	1	38	
Ruptured thoracic aneurysm	1	41	
Heart failure	1	—	

TABLE 10

Newark City Hospital Autopsies, 1908-1911: Digestive Diseases

Cause	Number	Median Age (years)	Range
Perforated gastric or duodenal ulcer	6	43	28 to 60
Strangulated hernia	2	30.5	22 to 39
Ruptured appendix	1	3	
Ileus from fibrous band obstruction	1	33	
Acute peritonitis	1	53	
Acute gangrenous colitis	1	27	
Sigmoid volvulus	1	65	
Cirrhosis of liver	8	46.5	34 to 57
Hemorrhagic pancreatitis	3	45.5	41 to 50
Choledocholithiasis with ascending cholangitis	1	26	
Multiple liver abscesses from suppurative cholangitis	1	14	
Hepatitis	1	70	

TABLE 11

Newark City Hospital Autopsies, 1908-1911: Renal Diseases

Cause	Number	Median Age (years)	Range
(Chronic) nephritis	16	46.5	23 to 70
Chronic nephritis with uremia	6	34	29 to 59
Chronic Bright's disease	3	67	25 to 70
Acute Bright's disease	2	44	38 to 50
Complications of urethral stricture	2	50	47 to 53
Post scarlatinal nephritis	1	25	
Rupture of urethra	1	—	
Renal calculi	1	52	
Suppurative cystitis with pyelonephritis	1	22	
Pyelonephritis	1	47	

reading. Malnutrition, marasmus, exposure combined with asphyxia, and exposure alone account for 9 of the 18 deaths in this group. These deaths very probably represent abandoned and neglected children, the oldest of whom was 12 months old, and surely constituted child abuse at least, and perhaps attempts at homicide by neglect.

Cardiovascular deaths differed substantially in their pattern in 1908 to 1911 from now, but interpretation of autopsy diagnoses without histologic confirmation is hazardous (Table 9). It was not until World War I that physicians began to take seriously the possibility that heart disease could be treated; hence, most of the diagnostic classifications that we now find intelligible were developed between the world wars.

Rheumatic heart disease was a very frequent cause of death and disability until ignorant general practitioners began to treat sore throats using antibiotics without waiting for bacterial culture reports. Most of the endocarditis and valvular heart disease in our series reasonably can be attributed to rheumatic heart disease. Thus, 17 of the 35 cardiovascular deaths in this series may be attributed to rheumatic heart disease. Syphilitic heart disease probably was responsible for the cases of aortic regurgitation and for the one ruptured thoracic aneurysm. One case was signed out only as "syphilitic heart disease." Thus, infection—streptococcal or treponemal—rather than arteriosclerosis caused 23 of the 35 cardiovascular deaths.

Arteriosclerotic heart disease's contribution to the other 21 cardiovascular deaths may be difficult to assess very accurately in retrospect. J.B. Herrick first described, in English, the clinical features of sudden obstruction of the coronary arteries in 1912, although the association between disease of the coronary arteries and angina pectoris and sudden death had been known at least since the 18th century.[3] Thereafter, what previously had been death from "acute indigestion" gradually became death from coronary thrombosis. Three of our autopsies describe what now we would consider coronary artery disease: coronary thrombosis, myocarditis with atheromatous coronary arteries, and hypertrophied dilated heart with fatty degeneration of coronary arteries. We also may suspect that most of the five deaths listed as "myocarditis," in fact, were due to myocardial ischemia, but without histologic confirmation, we cannot be sure.

Digestive diseases causing death (Table 10) were dominated by the six who died of the complications of perforated gastric or duodenal ulcers, and the eight who died of cirrhosis of the liver. Three deaths from acute hemorrhagic pancreatitis would not be unexpected in any city hospital population. Too few deaths from other digestive diseases permit us to identify a pattern. The two who died from strangulated hernias probably were compounded by late presentation to the hospital.

Renal disease interpretation, like diseases of the cardiovascular system 70 years ago, require caution. It is now quite impossible to determine just what the 16 patients who died of chronic nephritis really had (Table 11). We may suspect that this was an all-inclusive vague diagnosis and what was termed "chronic Bright's disease" now is almost uninterpretable. Chronic nephritis with uremia claimed 6, and postscarlatinal nephritis claimed 1 victim, but these 7

TABLE 12

Newark City Hospital Autopsies, 1908-1911: Infections

Cause	Number	Median Age (years)	Range
Lobar or bronchopneumonia	41	40	1 wk to 78 yr
Tuberculosis:			
Pulmonary	44	38.5	4 mo to 63 yr
Miliary	20	35	4 to 58
Meningitis	7	30	2 to 49
Intestinal	4	31	7 mo to 40 yr
Kidneys	2	48.5	35 to 62
Bladder	1	49	
Peritonitis	1	78	
Not otherwise specified	5	40	36 to 62
Erysipelas	5	38	8 mo to 57 yr
Typhoid fever	7	32.5	22 to 44
Diphtheria	4	3.5	6 days to 45 yr
Rabies	3	14	12 to 54
Tetanus	2	26.5	14 to 39
Malaria	1	33	
"Sepsis":			
Lung abscess, empyema	6	42.5	27 to 55
Streptococcal	1	50	
Secondary to pyarthrosis	1	61	
Peritonsillar abscess	1	58	
Suppurative pyosalpinx	1	29	
Gangrenous stomatitis	1	45	
Not otherwise specified	1	35	

TABLE 13

Newark City Hospital Autopsies, 1908-1911: Central Nervous System Diseases

Cause	Number	Median Age (years)	Range
Bacterial meningitis	9	36	6 mo to 71 yr
Cerebral hemorrhage	8	55	45 to 70
Meningitis or brain abscess following mastoiditis	4	16.5	3 to 30
Subdural hemorrhage	3	55	35 to 65
Cerebral thrombosis	3	41	37 to 45
Encephalomalacia	2	57	39 to 75
Poliomyelitis	2	8.5	7 to 10
Extradural hemorrhage, spinal cord	1	—	
Cerebral hyperemia	1	35	
Brain abscess	1	—	
CNS syphilis	1	37	
Multiple sclerosis	1	46	
Acute ascending paralysis, spinal cord	1	26	
Skull fracture during epileptic fit	1	42	

patients probably died from what we now would classify as chronic glomerulonephritis of some sort.

Infections accounted for 159 of the 537 deaths in our series for which we have even rudimentary diagnoses, and constitute just under 30 percent of the total (Table 12). Lobar pneumonia and bronchopneumonia, "captains of the men of death," took 41, while the various forms of tuberculosis killed 84—15.6 percent of all of the autopsies during 1908 to 1911 attributed death to one form or another of tuberculosis. Deaths also occurred from infections that would now be medical, or at least autopsy, curiosities: typhoid fever, diphtheria, rabies, and tetanus. Malaria claimed 1 life and erysipelas—before modern antibiotics was a properly dreaded disease—killed 5. Generalized sepsis, our septicemia, from other infections accounted for 12 deaths.

Central nervous system disorders (Table 13) caused 38 deaths, but 13 of these were from bacterial meningitis and 1 from a brain abscess: bacterial meningitis then was common, and meningitis or brain abscess was a frequent and lethal complication. The 8 deaths from cerebral hemorrhage almost certainly were related to untreated hypertension, but the protocols provide neither heart weights nor measurements of the left ventricular wall, so this must remain conjectural. The 3 deaths from cerebral thrombosis and the 2 from encephalomalacia would now be ascribed to complications of cerebral arteriosclerosis, although the patients with cerebral thrombosis do seem a bit young. Subdural hemorrhage and extradural spinal cord hemorrhage are usually posttraumatic. One patient died from central nervous system syphilis, 1 from multiple sclerosis, 1 from an ascending paralysis, and 1 of a skull fracture sustained during an epileptic fit. Two died of poliomyelitis, and we cannot be

TABLE 14

Newark City Hospital Autopsies, 1908-1911: Miscellaneous Causes of Death

Cause	Number	Median Age (years)	Range
Protocols blank	26	37.5	SB to 68 yr.
Alcohol related			
Delirium tremens, "wet brain"	12	37	25 to 62
Acute alcoholism	1	56	
Chronic alcoholism	1	57	
Broke leg when drunk	1	36	
Subdural hematoma from fall when drunk	1	35	
Endocrine diseases			
Diabetes mellitus	2	55	50 to 60
Addison's disease	1	16	
Miscellaneous			
Senility	2	70.5	70 to 71
Exhaustion	1	49	
Progeria	1	16½	
Pernicious anemia	1	—	
Morphine given to a patient with nephritis	1	—	
Uremia with lung and kidney infarcts	1	49	

TABLE 15

Newark City Hospital Autopsies, 1908-1911: Malignant Neoplasms

Classification	Number	Ages
Colon	4	38, 43, 63, 78
Esophagus	3	40, 44, 45
Rectum	3	41, 60, 71
Uterine cervix	3	50, 52, 60
Chronic lymphatic leukemia	2	40, 45
Glioma, gliosarcoma	2	10, 53
Tongue	2	52, 66
Pancreas	2	52, 60
Hodgkin's disease	1	35
Acute lymphatic leukemia	1	18
Jaw	1	60
Stomach	1	64
Larynx	1	70
Bronchus	1	40
Prostate	1	—
Endothelioma, pleura	1	8
Vulva	1	34

sure what "cerebral hyperemia" meant.

Alcohol directly caused 16 deaths, 12 during delirium tremens or from alcoholic "wet brain" (Table 14). This total of only 3 percent of city hospital deaths in 1908 to 1911 as alcohol-related is remarkably low, probably from gross underreporting. Without blood alcohol assays, there is no way to determine how extensively alcohol may have contributed to other illnesses, and particularly to accidents and homicides.

Endocrine-related deaths include two from diabetes mellitus, patients aged 50 and 60 respectively, so that this was likely to have been of the nonketogenic maturity-onset variety. Juvenile diabetics did not live very long before the availability of insulin. One 16-year old died of Addison's disease, but the record does not make its etiology clear.

Miscellaneous deaths include a 16½-year-old girl who died of progeria. She was a patient of Dr. William H. Martland, Harrison Martland's father. Senility claimed two lives and exhaustion claimed one. One patient each died of pernicious anemia, of uremia with renal and pulmonary infarcts (etiology unknown), and one with nephritis who was unwisely given morphine.

In the United States, in 1910, the annual death rate for malignant neoplasms (including the hemolymphatic systems) was 76.2/100,000, and in 1970, it was 162.8/100,000. Malignant tumors (Table 15) contributed only 30 deaths to this series—5 percent of the whole. The most striking thing is that only 1 death was due to bronchogenic carcinoma and, indeed, in 1908 to 1911 bronchogenic carcinoma was a pathologic curiosity. Moreover, none of the women in this series died of cancer of the breast.

Table 3 reviews some common causes of death in 1910. Comparing these against our autopsy series, diabetes mellitus, cardiovascular disease, pneumonia, and gastritis (i.e. enteritis, duodenitis, colitis,) are underrepresented in this series. Motor vehicle accidents, homicides, and suicides are overrepresented, perhaps because Martland was the coroner's physician. But deaths from malignant neoplasms in our 1908 to 1911 autopsy series are only slightly fewer than what would have been expected from the general death rates at that time. It does not appear that patients with cancer selectively stayed out of the hospital to any significant extent. Not all of the increase in deaths from malignant neoplasms between 1910 and 1970 can be dismissed as an effect of longevity in the population or of better case finding. Two generations ago pathologists very accurately could tell benign from malignant, although their diagnostic classifications were less complicated than ours. It is clear that they saw proportionately fewer cancers than we do.

Accidental deaths (Table 16) tell us a good deal about the environment—occupational and domestic—from which our patients came; without clinical summaries, autopsies cannot provide much background information. Of the 80 deaths classified as accidental, how do we interpret the 25 for whom we have only the bald diagnosis of "skull fracture"? One patient also died of meningitis following an accidental skull

TABLE 16

Newark City Hospital Autopsies, 1908-1911: Accidental Deaths

Cause	Number	Median Age (years)	Range
Skull fracture, not otherwise specified	21	44.5	4 to 71
Automobile accident	6	50.5	8 to 84
Broken neck or back	5	40	25 to 62
Accidental gunshot	5	17	3 to 32
Trolley accident	4	45	35 to 57
Railroad accident	4	28	18 to 33
Multiple injuries, not otherwise specified	3	42	30 to 47
Anesthetic (chloroform) misadventure	3	30	24 to 32
Hip fracture	3	70	67 to 73
Heat stroke	2	56	56 to 56
Wagon accident	2	65.5	52 to 79
Wood alcohol ingestion	2	37.5	30 to 45
Horse	2	42.5	29 to 56
Rib fractures with pneumothorax or hemothorax	2	50	28 to 72
Illuminating gas	1	83	
Hanging	1	—	
Hit by brick	1	22	
Motorcycle accident	1	46	
Meningitis following skull fracture	1	56	
Fractured pelvis jumping from window at fire	1	23	
Subpial hemorrhage, scalp hematoma	1	40	
Falls: From window	1	30	
From fire truck	1	50	
Not otherwise specified	1	61	
On railroad station platform	1	36	
Down stairs	1	37	
Off stoop of house	1	—	
From scaffold	2	40.5	30 to 51
Down elevator shaft	1	16	

fracture, 2 died of rib fractures with pneumothorax or hemothorax, and 1 died of a scalp hematoma with subpial hemorrhage. Eighteen accidental deaths involved various modes of transportation: 6 automobile accidents, 4 trolley car, 2 horse-drawn wagon, and 1 motorcycle, while 2 were killed by horses in unspecified manners. Four died in railroad accidents, but it is not clear whether as employees or as passengers because details simply are too sparse.

Accidental gunshot wounds killed five persons; the median age was 17, and ranged from 3 to 32. Three died from anesthetic mishaps, usually tonsillectomy. The anesthetic was chloroform and usually the operations were done on outpatients. Two drank wood alcohol, one died from illuminating gas at age 83, one was hit by a flying brick, and one broke his pelvis jumping from a window at a fire. There were five broken necks or backs, three cases of multiple and not further specified injuries, three hip fractures, two heat strokes, and one accidental hanging. Falls were frequent causes of death: windows, fire trucks, railroad station platforms, staircases, front stoops, scaffolds, and—inevitably—a 16-year-old boy was killed when he fell down an elevator shaft.

Murder was much less frequent than in today's large cities, but was even then a young man's game (Table 17). Gunshot and homicidal skull fractures each took six lives, and one each died of kicking, stabbing, assault with a shovel, and—an act of truly Edwardian elegance—a hatpin wound of the heart. The pattern of homicides (murder is a jury verdict) in our series suggests random violence. None of the 16 homicides in this series looks like an assassination and, although quite impressively violent street gangs existed in large cities at the time, Newark's Health Department reporting area recorded only 9 homicides during 1910. Crime never was organized until Prohibition.

Suicide methods change with time. Gunshot was chosen by four young victims, aged 23 to 34. Their elders took arsenic, usually as Paris green, or inhaled carbon monoxide. Each of two 21 year olds took morphine, easily available over the counter, and five other suicide victims used, respectively, bichloride of mercury, carbolic acid, a mixture of arsenic and ammonia, bichloride of mercury and carbon monoxide, and one unidentified poison.

CONCLUSIONS

What do these autopsy protocols tell us about the lives of the people who died in Newark City Hospital between 1908 and 1911? Although our conclusions must be tentative, we can offer some suggestions about what things were like for the urban poor whom the hospital served at that time.

In 1908 to 1911, prosperous citizens of Newark were born and usually died at home. They often were operated upon at home, or in small private hospitals. They did not come to Newark City Hospital by choice, although they may have been carried there by ambulance following an accident. Hence, in 1908 to 1911, Newark City Hospital retained many characteristics of late 18th and early 19th century charity hospitals in that it provided care for those whose domestic resources or network of human ties could not accommodate

TABLE 17

Newark City Hospital Autopsies, 1908-1911: Homicides and Suicides

Cause	Number	Median Age (years)	Range
Homicides:			
Gunshot	6	32	28 to 38
Skull fracture	6	35.5	26 to 60
Hatpin wound of heart	1	—	
Hit by shovel	1	30	
Kick to abdomen	1	35	
Stabbing	1	18	
Suicides:			
Gunshot	4	28.5	23 to 34
Arsenic, Paris green	4	62	48 to 69
Carbon monoxide	3	59	20 to 66
Morphine	2	21	21 to 21
Mercury bichloride	1	17	
Arsenic and ammonia	1	16	
Carbolic acid	1	—	
Mercury bichloride and carbon monoxide	1	34	
Poison, not otherwise specified	1	34	

their births, illnesses, surgical operations, or dyings.

In 1908 to 1911, poverty clearly left a great many people no alternative to Newark City Hospital. Poor people do not live as long as rich people, they seek medical advice later during the courses of their illnesses, and their responses to the stress of illness and injury sometimes are less effective than they might be. Malnutrition, fatigue, chronic depression, hopelessness, and other intangibles are common among the poor. Most of our patients died when they were between 25 and 54, and especially when they were between 35 and 54. At the very stage in life when privileged or middle-class citizens were getting nicely started in their lives and careers, our patients were reaching the ends of theirs. To be blunt, as late as 1910, the lives of many of the patients whom Newark City Hospital served were as nasty, as brutish, and as short as they would have been 100 years earlier.

Conventional wisdom regards tuberculosis and rheumatic heart disease as related to poverty, to overcrowding, and to marginal diet. We may suspect the same of the meningitis in our series. Mortality from both tuberculosis and rheumatic heart disease began to fall long before the development of modern antibiotics as housing and diet improved, but we safely can suggest that this improvement had not exerted its full impact on the poor of Newark by 1910.

In 1908 to 1911 Newark, patterns of death among children —malnutrition, marasmus, exposure, asphyxia—suggest that infanticide by neglect, man's oldest form of population control, still was operative. The complications of childbirth were not problems for adolescent girls, and only 1 of the 19 mothers in our autopsy series was younger than 20. She was 17—young, but by the standards of the time, nubile. Abortion-related complications did not fill the wards, and in 1908 to 1911, deaths from "unplanned pregnancies" were only peripheral concerns at Newark City Hospital. We therefore may suggest that sexual lives were perhaps better disciplined in Newark than now.

Cancer was not so frequent a cause of death as now is the case. This change is real, and merits serious exploration although no useful opinion can be offered as to why this is so until a much larger statistical base permits us to assess the relative impact of changes, over time, in the incidence of site-specific tumors. The increase in bronchogenic carcinoma alone during the past generation has affected the cancer death rate enormously, but careful and accurate retrospective reviews might yield some provocative insights. Prior to World War I, for example, cigarette smoking and wrist watches were viewed widely as effeminate and macho men avoided both. Of our entire series, only one bronchogenic carcinoma was recorded and no deaths that, on review, seemed to be from chronic obstructive lung disease. We may suggest that whatever lifestyle or environmental factors explain this increase in cancer deaths, they were less potent or frequent two generations ago.

Old people were not abandoned in Newark City Hospital; it was neither a geriatric hospital nor a nursing home.

In 1908 to 1911, murder was vastly less frequent than now, and murderers ran a considerable risk of being executed. The criminal justice system may have done things that would upset the American Civil Liberties Union, but it seems to have been effective at least in preventing murder. Deaths from drug overdoses were unheard of, except when taken as abortifacients or with suicidal intent. None of the autopsies in this series suggested sexual abuse; we can be reasonably sure that had such victims died in the hospital, Martland—as the coroner's physician—would have done the autopsy.

Our 1908 to 1911 autopsies include fewer homicides than now would be the case, and no fatal sexual assaults. Certain bacterial diseases now are curable that then usually were lethal. There were far more deaths from such diseases as tuberculosis and rheumatic heart disease, which generally are attributed to poverty and which may be good indices of real deprivation. More workers seem to have been killed at work than now. But we also may have to suggest that despite considerable real poverty, Newark then was a much safer and less violent place to live.

REFERENCES

1. Annual Report of the Department of Public Health, City of Newark, N.J., for the Year 1910.
2. Samuel Berg: *Harrison Stanford Martland.* New York, NY, Vantage Press, 1978.
3. Herrick JB: Clinical features of sudden obstruction of the coronary arteries. *JAMA* 59:2015-2020, 1912.

PEDIATRIC BRIEFS

Selected Abstracts with Comments*

Leiken SL: Minors' assent or dissent to medical treatment. *Pediatrics* 102:169, 1983.

This essay by an oncologist argues for a flexible and individualized approach to the inclusion of minor patients in treatment decisions. In general, children 14 years of age or older have developed the elements of cognition required for rational consent. Voluntariness, i.e. independence from overwhelming conformity needs, also is required for true consent. Fourteen or 15 years of age, generally speaking, is the earliest that children may be expected to dissent in the presence of parents who already have agreed to a proposed treatment. However, the variability in psychologic development and in other factors (i.e. social class or prior experience with illness and hospitalization) is so great that no arbitrary age criteria will suffice to determine how a child should be included in the decision process.

The goal of such determination is to avoid disrespect for the minor on the one hand and to avoid unrealistic expectations of competence on the other. The responsible health care professional who makes or participates in the making of these determinations will: (1) be informed by the work of Piaget et al. on "levels" of cognitive development; (2) make careful assessments of the individual minor's "levels" of psychologic and social development; and (3) honor the child by respecting him/her at the "level" of competence which a careful assessment demonstrates. This means, for example, that if a minor is judged on good clinical grounds as being able to assent meaningfully to proposed treatment and then dissents, the dissent should be honored as well. Often, however, a minor will not be assessed confidently as able to decide autonomously. In such cases, there is an obligation to inform and include the child when treatment decisions are being considered by others. Here, the determination of competence is not so critical. It is not respect for autonomy which is at stake, but humane treatment and efforts to strengthen the therapeutic alliance. Even so, there remains the general obligation to deal with any patient openly and honestly. Moreover, the decisions reached by physician and parents should accommodate the minor's needs and values, even though he/she is not accorded the right to assent or dissent.

Comment: I agree wholeheartedly. The developmental approach to assessing competencies, and hence appropriate involvement in decision making, makes great sense. Here is another clear instance where psychological sophistication and careful clinical assessment is required to give effect to our moral commitments. Every pediatrician should know about cognitive development (and its corollaries for conceptualization of illness). Every pediatrician should practice assiduously the assessment skills required to determine the appropriate involvement of minors in treatment decisions. The moral force behind these standards of knowledge and skill is derived from the ethical obligation to provide autonomy to those individuals capable of assuming it, without denying protection to those who are not. (D. Price, Ph.D, Adj. Asst. Professor, Health Care Humanities)

Vu NV, et al.: How medical students learn. *J Med Educ* 58:601, 1983.

Medical school faculties have emphasized what students should learn rather than how to learn. Recently, the Association of American Medical Colleges stated that medical students must be steered toward development of independent and analytic learning skills. In a comprehensive analysis of how students learn in the first two years at two United States medical schools (one with a traditional curriculum, the other with an "objectives-based mastery curriculum"), the authors concluded that the medical students they studied would not be effective lifelong learners because they adopted behaviors antithetical to same. They did not have well-planned study systems and they were not motivated to active searching of learning beyond expectations of their teachers. There was evidence of development of analytic skills, however. The authors state "students do not possess independent learning skills [upon entry] and seem not to develop them [during the first two years]." They speculate that the curriculum in the first two years may be so overloaded that "students adopt only those learning behaviors which help them cope with curriculum requirements. . .[and] the structure and frequen-

*Abstracts are from the Department of Pediatrics *Newsletter,* UMDNJ-New Jersey Medical School, Vol. 8, No. 9, 1983. Selections are made by Richard J. Rapkin, M.D., Medical Director of Children's Hospital, Newark, who is Editor; and by Coeditors, Franklin C. Behrle, M.D., Professor and Chairman, Department of Pediatrics, UMDNJ-New Jersey Medical School, and Shyan C. Sun, M.D., Director of Neonatology, Children's Hospital, Newark. Correspondence may be addressed to Dr. Rapkin, Children's Hospital of New Jersey, 15 South 9th Street, Newark, NJ 07107.

cy of examinations in medical curricula may inhibit even the most self-confident and independent student from learning in his own way." They recommend that "curriculum committees and faculty members need to create an environment in which students can learn effectively and efficiently and one which encourages . . . self-directed learning habits." They make four suggestions: (1) curricula with gradually less structure on students' learning; (2) provision of time for independent learning and reduction of amount of information required; (3) replace some examinations with self-evaluation exercises; and (4) research the subject of curricula change and its relation to student learning behaviors.

Duff GW, et al.: Fever and immunoregulation. *Yale J Biol Med* 55:437, 1982.

Fever is mediated by a polypeptide (endogenous pyrogen [EP]) produced by macrophages. Interleuken 1 is a macrophage-made-polypeptide which stimulates T lymphocyte proliferation. Interleuken 1 and EP probably are identical. Hyperthermia (in vitro cell studies) increases the T cell response to EP. "If naturally occurring fever influences the immune response in vivo to the extent suggested by our observations in vitro, then the role of fever as a host defense may warrant further examination. For example, antipyretic drugs may be useful in autoimmune diseases where the immune response is detrimental to the host, but when the immune response is to the host's advantage (e.g. directed against infections or neoplastic cells), then fever itself may be beneficial. . . .[These findings] call into question the current indiscriminate use of antipyretic agents."

Gershel JC, et al.: The usefulness of chest radiographs in first asthma attacks. *N Engl J Med* 309:336, 1983.

Three hundred seventy-one consecutive children over age one year with initial wheezing episodes had radiographs. Of those with "positive" films (abnormal beyond the usual findings in asthma), 95 percent could be predicted clinically by signs in combination: tachycardia, fever, and localized findings (rales or decreased breath sounds). Routine radiographs are not necessary in the vast majority of first-time wheezers over age one.

Comment: I was brought up on "all that wheezes is not asthma" and urged to obtain a chest x-ray whenever seeing a (presumed) asthmatic for the first time or whenever such children warranted admission for status. This study did not address the latter situation which remains, for me, a significant illness requiring careful evaluation among which is a chest x-ray. I am not looking for subsegmental atelectasis (often mislabeled and mistreated as pneumonia) but rather evidence of laterality (e.g. foreign body), pneumothorax or pneumomediastinum, or significant underlying lung disease. I will not quarrel with the authors' conclusion that chest radiographs are superfluous in many patients with wheezing. These patients most often are seen in physician office practices and, I would guess, rarely get radiographs unless they are to be admitted. The latter patients are a different group and until a large study is done on those, I will remain traditional in my approach.

Staheli LT: In-toeing and out-toeing in children. *J Fam Pract* 16:1005, 1983.

Causes of in-toeing include: (1) Metatarsus adductus (of which 85 percent resolve without treatment). Rigid deformity or failure to resolve spontaneously in six to nine months is an indication for simple casting. (2) Internal tibial torsion (which rarely persists). No treatment has been proved effective for the remainder. (3) Medial femoral torsion (this often gets worse for a few years and then improves spontaneously). No treatment is indicated since none has been proved effective. The only cause of out-toeing is tibial torsion and no treatment is known. Rotational osteotomy for many of these conditions is "one of the most risky operations in orthopedics." Inappropriate therapies include shoe modifications which are "ineffective, waste family resources, and embarrass the child". Orthotics have no place in management of these conditions.

Comment: Dr. Staheli is a careful pediatric orthopedist. My own beliefs are supported by his observations and literature review. In-toeing and out-toeing are rarely of significance, usually are self-limited and, even if persistent, are only cosmetic. There is no proved safe and effective treatment but many expensive and dangerous ones. The physician should beware and be resistant to proposed cures until evidence is forthcoming.

Campbell JB, et al.: Foley catheter removal of blunt esophageal foreign bodies. Experience with 100 consecutive children. *Pediatr Radiol* 13:116, 1983.

One hundred consecutive children with blunt esophageal foreign bodies were treated with a nonoperative method of foreign body removal utilizing a Foley catheter. Dislodgement was successful in 98 children. There were no complications. Performed properly, the technique is rapid and safe. It precludes hospitalization and even the slight hazards of endoscopy and general anesthesia.

Comment: I certainly agree with the approach of the above writers in handling blunt esophageal foreign body nonoperatively in the x-ray department under fluoroscopy using the Foley catheter technique. This is a very old method being reported frequently in the literature and should be kept in mind in handling children with this type of foreign body. Only children with a blunt esophageal foreign body are candidates for this technique. If this method fails in removing the foreign body or successfully pushing it to the stomach, the patient should be taken to the operating room and, under general anesthesia, the foreign body should be removed with instrumentation. (S. Saad, M.D., Asst. Professor, Pediatric Surgery.)

IMPAIRED PHYSICIANS PROGRAM

Monitoring

DAVID I. CANAVAN, M.D., Lawrenceville*

The high incidence of recidivism that is associated with the diseases of impairment; the frequency of involvement with disciplinary boards at the hospital and state level; and our responsibility to the public, the profession, and the individual impaired physician mandate an effective program for monitoring the continuing recovery of our clients.

Because of the ever-increasing number of physicians in our program, it becomes more and more difficult for the medical director to supervise personally all of the clients to the extent that we would like. It is essential that a well-coordinated network be available to assist in this critical function. There now are several different phases of our monitoring program in operation. The followup of each individual, however, is tailored to that physician's own special needs and the nature of the impairment involved. We try to personalize this program to the extent that it is possible.

PHASE I: FOLLOWUP CONTACT WITH THE INITIAL REFERRAL SOURCE

In the experience of our program, the initial referral usually is from a seriously concerned individual who cares deeply about the impaired physician. These usually are close colleagues, family members, office personnel, or hospital staff members who continue in close contact with the recovering physician and are as intimately aware of the physician's continuing recovery as they were of the downhill spiral of his original impairment. These people are an excellent and usually quite reliable source of information on the doctor's progress or the lack thereof.

PHASE II: COMMITTEE ON IMPAIRED PHYSICIANS

An important part of the role of the members of the Committee on Impaired Physicians is their function as local monitors. We have divided the state into regions. Each region has a regional coordinator who is a member of our Executive Subcommittee. Each member of the Committee is assigned to one of the regional teams and has the responsibility of monitoring the progress of physicians assigned to him and reporting regularly on the physician's recovery either to the regional coordinator or directly to the medical director. Very often the monitor is the same physician who participated in the initial confrontation and, therefore, is known to the physician client. Whenever possible, each physician client has an assigned local physician monitor.

PHASE III: THE MEDICAL DIRECTOR

The medical director in addition to, or occasionally in place of, the local monitor, attempts to maintain personal contact with all the physician clients in the program. He takes over this responsibility if the physician lives in an area of the state where there are no close monitors available. All physician clients are made aware of their right of access to the medical director at any time that they feel he can assist them in any area of their recovery. For those physicians whose problems are most severe, and often therefore most involved, the medical director assumes the responsibility of the burden of their followup. This close contact with a concerned physician from the Committee on Impaired Physicians is a key element in the ability of the program to succeed.

PHASE IV: ATTENDANCE RECORDS

One of the important aspects in assisting the recovering physician in dealing with administrative issues at the hospital or the State Board level is the ability to document the physician's participation in a structured recovery program.

We have developed an attendance record card as one means of providing this documentation.

It is a principle of the support group philosophy that attendance is not taken at meetings of the groups. However, when an individual member, for his or her own personal needs, requires documentation, the group secretary is able and authorized to confirm the member's attendance. The attendance card is identified with the physician's code number so that if it is lost it does not reveal the identity of the impaired physician to the person who finds it. This card also assists us in documenting the frequency with which the physician attends and enables us to measure performance versus our recommendations.

*Dr. Canavan is Medical Director, Impaired Physicians Program. Correspondence may be addressed to Dr. Canavan, MSNJ, Two Princess Road, Lawrenceville, NJ 08648.

PHASE V: URINE MONITORING

In the case of physicians whose problem is the abuse of drugs, other than alcohol, our most valuable documentary tool is the ability to monitor the physician's urine for the presence of mood-altering drugs. With the close cooperation of the Division of Laboratories of the New Jersey Department of Health, we have been able to structure a very effective program for the substance-abusing clients in our Program.

The physician client presents himself or herself at one of the 15 state-sponsored drug abuse clinics. Only the clinic director is aware of the physician's identity. The physician provides a fresh urine sample under direct observation. The sample then is labeled with the physician's code number and forwarded under the code number to the State Department of Health laboratories in Trenton where it will be analyzed for the presence of up to four different classes of mood-altering drugs. Testing for a total of eight different classes of drugs is available. Our office selects the four classes for each specimen. We can vary this each time if we choose to do so. We also control the randomicity of the specimens.

The test results are forwarded, under the code number, to MSNJ headquarters in Lawrenceville. Only two people have access to the code: the medical director and his secretary.

Positive urine results immediately are pursued with the physician involved. There is occasional cross reactivity with benign substances and these must be ruled out carefully. The urine test results are very accurate. When a choice must be made between the reliability of the urine and the reliability of the client, the edge goes to the urine test.

Urine monitoring, in these cases, serves three important functions: it is a constant reminder to our recovering colleagues that "big brother" is watching; it is an excellent early warning system and promptly alerts us when our client begins to "slip"; and it is excellent documentation of the drug-free state for submission to administrative boards.

It should be apparent that the Impaired Physicians Program considers close monitoring of our clients a major responsibility. Without it, the initial gains of early identification, confrontation, appropriate treatment, aftercare, and support groups easily could be lost.

AN ACT OF LOVE

Their own **DENIAL** that a respected colleague could be **IMPAIRED** and/or the "conspiracy of silence" that makes them unwilling to speak out allows the illness of our impaired colleagues to progress, sometimes to a fatal outcome.

"Blowing the whistle" on a suffering colleague is indeed an **ACT OF LOVE!**

Call Us **EARLY**
We can help **CONFIDENTIALLY**
IMPAIRED PHYSICIANS PROGRAM
(609) 896-1766
Hot Line . . . (609) 896-1884

A WORD TO THE WHYS

WHY AMA?

The AMA actively works to represent your interests by fostering legislation that is beneficial both to the medical profession and the public. Each year the AMA makes thousands of contacts with members of congress and their staffs and frequently translates Association policies into model or draft legislation for governmental action. Active representation of organized medicine: it's one more good reason why you should be part of the AMA.

WHY AMA?

Today you can have instant access to a broad range of up-to-the-minute clinical information and protocols for use in patient care through the Medical Information Network. This nationwide, computerized system was developed by the AMA, with General Telephone and Electronics (GTE), to provide you with the most advanced, current scientific information. It's one more reason why you should be a part of the AMA.

WHY AMA?

Residents and medical students now have a strong voice in organized medicine. Through the Resident Physician Section and the Medical Student Section, these two groups participate in the policy making process of the AMA and communicate their concerns. Developing future leadership in organized medicine: it's one more good reason why you should be a part of the AMA.

To Join, Contact your county or state medical society or write: Division of Membership, AMA, 535 North Dearborn Street, Chicago, Illinois 60610 or call collect, (312) 751-6196.

AMA
AMERICAN MEDICAL ASSOCIATION

Trustees' Minutes November 20, 1983

A regular meeting of the Board of Trustees was held on Sunday, November 20, 1983, at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

Report of the Executive Director . . .
(1) MSNJ Financial Statements . . . Approved the financial statements for the periods ending September 30 and October 31, 1983.
(2) State Board of Medical Examiners (SBME) . . .
(a) Approval of Letters of Admonishment and Criticism . . . Noted that before letters of admonishment are issued, physicians will have the opportunity for a hearing with the SBME.
(b) Proposal To Amend Ruling on Advertising . . . Was advised that the Board will have the opportunity to review and comment on amendments to the ruling on advertising when the proposal is developed by the SBME.
(3) Litigation
(a) SBME *v* Strauch and Aluri . . . Noted that the decision of the SBME in both cases was upheld by the Appellate Division; a petition for certification has been filed by the New Jersey Supreme Court.
(b) Subordinated Loan . . . Noted that the trial date was set for December 14, 1983, in Tax Court.
(4) Professional Liability Rates . . . Was informed that the Board of Governors of the Medical Inter-Insurance Exchange of New Jersey has voted to file a rate request that will increase all professional liability rates by 13.7 percent effective February 1984.
(5) Licensing and Regulation of Athletic Trainers—A-3262 . . . Approved the referral of the bill to the chairmen of the Council on Legislation and the Committee on Sports Medicine to determine whether the amended version possibly could produce a change in MSNJ's position of active opposition.

UMDNJ Report . . .
(1) New Jersey Blood Banks . . . Was alerted to the possibility that an article to be published in the *New England Journal of Medicine* may cause a problem for blood banks in New Jersey; the article reports on cases of AIDS involving persons who received blood transfusions.
(2) President's Contract . . . Congratulated Dr. Bergen on receiving the approval of UMDNJ's Board of Trustees for the extension of his term as president through June 30, 1989.

New Jersey Hospital Association . . .
(1) Disciplinary Proceedings and Malpractice Actions . . . Noted that the report form used for reporting disciplinary actions or proceedings against a physician as well as any malpractice actions should state that the final disciplinary action was taken against the physician by the governing board of a health care facility and does not involve an administrative matter.
(2) Licensing and Accreditation . . . Noted that the Board of Trustees of the New Jersey Hospital Association endorsed the following position:

a. Hospitals should have the right to voluntarily use Joint Commission accreditation as an alternative to duplicate licensing surveys.
b. The hospital would submit to the Department of Health a copy of its Joint Commission survey results.
c. When the Department of Health utilized the Joint Commission survey results for purposes of assuring compliance with licensing standards, it would agree to maintain the strictest confidentiality of the Joint Commission findings.
d. The Department of Health would accept accreditation for licensing purposes with the understanding that the Department would need to retain the right to validate or audit.

(3) Definition of Death . . . Noted that with the change in wording in bill **S-140** (Uniform Determination of Death Act) which refers to the discontinuance of "life support" measures, the New Jersey Hospital Association now supports the legislation.
(4) Facility Definition . . . Agreed that a strong effort should be made to reach a mutually acceptable form with the New Jersey Hospital Association on the issues involved before legislation is introduced.

MSNJ Student Association . . . Received as informative the monthly report of the MSNJ Student Association noting membership figures, a donation of $500 from the Essex County Medical Society, suggestions for speakers for business of medicine seminars, and mention of the first issue of the student newsletter.

Council on Medical Services . . .
(1) Corporate Restructuring of New Jersey Hospitals . . . Approved and effected the following recommendations:

That the Medical Society of New Jersey objects to the fact that it was not asked to have a member participate in the deliberations of the Blue Ribbon Committee on an issue bearing directly on the practice of medicine.

That the Medical Society of New Jersey objects to recommendation #1 contained in the Blue Ribbon Committee's report, which recommends broader application of regulatory principles to all providers of health care.

That the Medical Society of New Jersey wishes to participate in any discussions on the development of a definition of "core" hospital services if such a definition is needed.

Referred back to the Council on Medical Services for an explanatory statement on unbundling, the following recommendation:

That the Medical Society of New Jersey understands and recognizes the economic need for some hospitals to unbundle.

Approved the following recommendation:

That the Board of Trustees make a strong statement, with explanations, opposing the

application of certificate of need regulations to physicians' private offices, and that all the recommendations be conveyed to the Commissioner of Health.

(2) AMA Council on Medical Service Report on Physician Reimbursement . . . Approved the following recommendation:

That the Medical Society of New Jersey supports pluralistic methods of reimbursement to include, *but not limited to,* UCR, private billing, and indemnification. (Italics indicate an editorial amendment by the Board.)

(3) Resolutions #14, #15, and #16—House of Delegates . . . Referred the following recommendation back to the Council on Medical Services for review and a restatement:

That the Board of Trustees strongly protests the legislation that now governs the generic prescribing system on the grounds that it affects adversely the quality of medical care and increases physician liability in prescribing drugs over which he has very little control.

(4) Statewide Health Coordinating Council (SHCC) . . . Approved the following amended recommendation:

That the Medical Society of New Jersey be allowed to designate a representative to the Statewide Health Coordinating Council (SHCC).

Council on Public Relations . . .
(1) Health Research and Educational Trust of New Jersey (HRET) . . . Voted to disapprove the following recommendation:

That the Board of Trustees approves the purchase of a TV dish in order to participate in the Healthcare Information Network Program.

(2) New Jersey Network . . . Approved the following recommendation:

That the Board approves spending $5,000 to support health programs on New Jersey Network-Consumer Line.

Committee on Medicaid . . .
Medicaid Personal Physicians Plan . . . Approved the following amended recommendation:

The Medical Society of New Jersey does not endorse the Medicaid Personal Physicians Plan as currently offered. The Society urges the Division of Medical Assistance and Health Services to reconsider the Pilot Project presented by the Division in September of 1980 for Atlantic and Mercer Counties, since it will serve as a means of improving the provision of medical care to Medicaid recipients.

Committee on Maternal and Child Care . . .
(1) Third Trimester Abortions (Resolution #17) . . . Approved the following recommendation:

That the Burlington County Medical Society be requested to reconsider Resolution #17 (Third Trimester Abortions) and resubmit it in proper form and content if they are interested in pursuing this issue further.

(2) Guidelines for Perinatal Study Conferences . . . Approved the following recommendation:

That the Medical Society of New Jersey endorses the "Guidelines for Perinatal Study Conferences," which will be distributed by the State Department of Health through the Maternal and Child Health Programs.

(3) Task Force on Fetal Alcohol Syndrome . . . Approved the following recommendation:

That the Medical Society of New Jersey endorses the educational goals of the Task Force on Fetal Alcohol Syndrome and urges all physicians caring for women of child-bearing age to bring the dangers of drinking to their attention.

Executive Subcommittee, Committee on Impaired Physicians . . .
(1) Full-time Alcoholism Counselor . . . Noted that there will be further discussion concerning the need for and addition of a full-time alcoholism counselor for the Impaired Physicians Program.
(2) Statement of the Problem . . . Approved the following recommendation:

That the Board of Trustees endorses the Statement of the Problem as an official document of the Impaired Physicians Program.

Noted that a copy of the full statement is available upon request.

Old Business . . .
(1) Future Physician Supply in New Jersey . . . Noted that according to correspondence received from Donald B. Louria, M.D., New Jersey will suffer from the doctor glut by 1990.
(2) Special Committee on Long-Range Planning and Development . . . Indicated that the Board would like to develop guidelines for the running and supporting of candidates seeking election or appointment to AMA office.

New Business . . .
(1) Denial of Payment to Surgical Assistants in Hospitals Having a Surgical Residency Program . . . Received correspondence from a Monmouth County member objecting to a provision under Medicare which stipulates that no payment may be made for the services of assistants at surgery furnished in a teaching hospital which has a training program related to the medical specialty required for the surgical procedure and has a resident available to perform the service. Noted that James E.D. Gardam, M.D., Vice-President of Medical Services, Governmental Health Programs Office of Prudential, suggested that where exceptional medical circumstances exist, the case will be reviewed on an individual basis.
(2) Preferred Provider Health Care Act of 1983 . . . Reviewed AMA comments on HR 2956, a bill that would preempt state laws regarding Preferred Provider Organizations (PPOs).
(3) Urgi-Centers . . . Will obtain information from Ohio, Tennessee, and Kentucky where legislation was enacted to regulate and control the development of urgi-centers and to require that these centers be subjected to the certification of need process.

President's Column

Alexander D. Kovacs, M.D.

As I write this, the outlook for the country as a whole is brighter than it has been in some time. The future looks good, but it does not look quite so rosy for physicians. We appear to be at the beginning of a decline. Most of us have yet to notice any real change in our practices or our lifestyles but change is in the air.

Will the changes result in better medical care? Recent statistics released by the federal government would indicate we are doing well now. The average life expectancy in the United States is the highest it ever has been. A baby born in 1982 can expect to live, on the average, to the age of 75. Our infant mortality rate is at its lowest. With a system this good, why would anyone want to tinker with it? You know the old saying, "If it isn't broke, don't fix it!"

In one sense, the system is broke or at least is going broke. Government doomsayers tell us that we no longer can afford all this good care. They still want it to be good—they just do not want it expensive. Health care costs represent 10.5 percent of the gross national product, and government, big business, and the unions are screaming. Because of the cost and because of public perception, unsupported by fact, that medical care

is not as good as it used to be, we are in a state of flux. Rapid changes are taking place and our futures will bear only a faint resemblance to our past.

At the first White House Conference on Aging, in the 1960s, the principle that access to medical care was a right for all citizens was first articulated; the means for such access was created through Medicare and Medicaid.

In the 1960s, unions were at the peak of their power. They demanded and received fringe benefits, most notably health insurance coverage. Big business thought it was money well spent even if the demand was for first dollar coverage.

A second problem became apparent quickly. With money for access to medical care, the demand was created for more doctors. American medical schools were built quickly and immigration regulations were eased to permit foreign medical graduates to fill the perceived shortage.

We had the money and the doctors. A combination like that leads to an increase in technology and our golden age was underway. We broke barriers in disease faster than ever before. We could cure more people of more illness than at any other time in history, and we did.

We did not do this alone. Hospitals and nursing homes were built to accommodate our patients. Nurses, technicians, administrators, clerical help, drug houses, and instrument manufacturers—an entire medical-industrial complex—was built based on the new ease of access and the money such access provided. Health care has become the nation's largest industry with expenditures of more than 300 billion dollars per year. Its phenomenal growth rate of 15 percent annually makes it the nation's second largest employer.

Now, society and government are alarmed at the size of their baby and its insatiable appetite. Their answer is: "The same level of care for less money." There are many proposals to reduce costs and some of them have merit. That a system should be as large as this without some waste is not possible. The big question is, "How much can you tighten the belt before the patient says ouch." We physicians are going to say ouch sooner than the patient.

Hospitals are readjusting faster than we are. They are looking to the future while we still bemoan the past. For-profit hospitals are one of the fastest growing segments of the industry. They can bypass the sick and poor and concentrate on patients with good insurance. Nonprofit hospitals are beginning to unbundle profitable services and set up satellites. They have organized themselves into cooperatives for the purchase of services such as laundry and food. They are hiring physicians to provide outpatient care formerly available only in a doctor's private office. They are hiring brains in the form of public relations experts to market their product.

Insurance carriers also are adjusting. Third-party payers are compiling lists of preferred providers, i.e. doctors willing to provide services for a negotiated fee. They also are cutting down on first dollar coverage.

Big business is renegotiating contracts to include givebacks. The unions, caught between shrinking memberships and economic distress, are accomodating themselves to the new reality.

What are we doing? First of all, we are trying to get our members to understand that a problem exists. At the same time, we are trying to adapt our own swollen ranks to the new rules of the game.

Competition? We must form partnerships between medical staffs and hospitals for market development. Cost containment? We must try to encourage such measures where the request for service originates—with the patient. We must discourage first dollar coverage and encourage individual responsibility. Public health? We must assume active roles in promoting healthy lifestyles, i.e. less junk food, no smoking, a reduction in alcoholic consumption leading to accidents, and reduction of air, water, and earth pollution.

There is a new era wherein neither the prevention of death from epidemics nor the correction of physiologically measurable abnormalities will be the objective. The new central objective of health care will be the maintenance or improvement of individual patient functioning in the patient's normal environment while he/she performs usual activities.

If we are to survive, we must do it by working together for the common good. None of us are going to get everything we want. We will have to make some concessions. We will have to accept that the majority of doctors no longer will be in the solo private practice of medicine. We will have to stretch to accommodate the younger physician, the salaried physician, and the preferred provider. We must realize that we cannot allow our profession to be fragmented. We physicians must stand together in one united organization with the muscle to negotiate and to fight for all members. We must be active politically if we are to have an impact on our futures.

The lessons of history are there for us to learn. We ignore them at our peril.

UMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

The Hospital Corporation of America (HCA) has completed its first year as interim manager of the day-to-day operations of University Hospital, having established a foundation for pursuing critical short- and long-term hospital objectives. The hospital management company has recruited new leadership, realigned the hospital's organizational structure, furthered management training, and decentralized functions to increase efficiency and effectiveness and to maximize the hospital's full potential as a primary care facility serving Newark and as a major teaching and referral center serving all of New Jersey.

At a recent staff retreat attended by officials of UMDNJ and HCA, several hospital needs were re-emphasized. Among them were the need for automated information systems (computers) to store and transmit patient information and records and new high-technology equipment necessary to the hospital's role as a regional state referral center for many tertiary care services. Participants in the retreat also reaffirmed commitments to furthering the hospital's "centers of excellence" in areas such as cancer research and treatment, the handling of traumatic injury, and the care of high-risk maternity patients and newborns.

The contractural arrangement between UMDNJ and HCA is a three-year agreement and only an interim step in the overall plan for managing the hospital. During HCA's tenure, the UMDNJ Board of Trustees will continue to discuss the eventual structure for the most efficient and effective governance of the hospital.

UMDNJ and the St. George's University School of Medicine reached a rental agreement which enabled up to 190 students of the Grenada-based medical program to pursue a course in gross anatomy by using the facilities of UMDNJ-Rutgers Medical School, Piscataway. The agreement, effective November 9, was to continue for no longer than eight weeks. St. George's officials plan to re-establish the medical school on Grenada or another off-shore site by early in 1984. St. George's University faculty and students used a newly

constructed space as a gross anatomy laboratory at the medical school. A schedule was established under which UMDNJ provided the laboratory space for several hours Monday through Saturday. A lecture hall also was made available weekday evenings. St. George's University provided its own faculty and staff, its own cadavers, and all necessary educational supplies. Its students were not considered students of UMDNJ, but were subject to all rules and regulations of the UMDNJ-Rutgers Medical School. The program and rental was developed with the concurrence and approval of the New Jersey Board of Medical Examiners.

Victims of mild hypertension can receive free treatment through the Hypertension Intervention Trial (HIT), a program based on UMDNJ's Newark campus and designed to prove that these people can maintain health without drugs. The program, funded by a $700,000 grant from the National Institutes of Health's Heart, Lung, and Blood Institute, concentrates on diet and stress reduction.

Norman Lasser, M.D., associate professor of medicine at UMDNJ-New Jersey Medical School, and Norman Hymowitz, Ph.D., clinical associate professor of psychiatry, codirect the program. Earlier both led the national MRFIT program's New Jersey Medical School center. The staff includes 20 nutritionists, psychologists, and other health professionals.

A pioneering health care program for diabetics, designed to reduce the debilitating disorders often associated with the disease, is underway at the Newark campus of UMDNJ. The new ambulatory care program, which offers the use of a 24-hour insulin pump, focuses on an intensification of insulin therapy coupled with the daily self-monitoring of glucose levels of the eyes, kidneys, and nerves. The UMDNJ program is admitting diabetics who are 18 or older and insulin-dependent. In addition to the insulin and monitoring components, each patient receives comprehensive education on the disease, including proper nutrition, exercise, and other health-enhancing information. All patients will receive continuous followup care for the duration of the program, expected to be at least three years.

According to Margo Cohen, M.D., program director and chief of endocrinology at UMDNJ-New Jersey Medical School, patients are taught to test their blood sugar levels; if needed, they increase their insulin by adding injections or using the pumping device. Called the "Intensive Ambulatory Treatment of Insulin-Requiring Diabetes," and sponsored by a grant from the Hunterdon Health Fund, the program is modeled after a project being run by the National Institutes of Health at a number of medical centers across the country.

MSNJ Auxiliary

Gale Wayman,
President

The start of a new year finds your Auxiliary continuing to work hard in many areas. With our members serving on 14 councils or committees of the Medical Society and reporting to our Executive Board, we are trying to better serve MSNJ by becoming better educated.

Our legislative chairman, Mrs. Frank Campo, and JEMPAC chairman, Mrs. Frank Romano, Sr., have been doing an outstanding job in keeping the membership aware of what is happening with medical legislation. Our members are kept abreast of "legislative alerts" and are asked to write their legislators. We are aware of the problems with PPOs and DRGs and by educating our members on these and other problems facing medicine, we are able to speak upon issues that affect our hardworking spouses who many times do not have the time to defend and protect themselves. We are asking our members to become involved in the political process because their involvement can make a difference.

AMNJ Report

Paul J. Hirsch, M.D.
President

The membership of the Academy of Medicine of New Jersey continues to grow, as it has over the last several years. Nevertheless, the Board of Trustees remains interested in encouraging new applicants for membership. At the recent meeting of the Board, the membership committee was directed to review our procedures for new applicants, with a view towards streamlining. For example, now it is required that each applicant provides three sponsors. It is proposed that two, or perhaps even one sponsor, would be sufficient. At the same time, the Board wishes to maintain an appropriate screening procedure. Dr. Benjamin Rush, chairman of the membership committee, will review these policies with his committee.

Dr. Alfred Alessi, chairman of the education committee, recently reported to the Board about a new interactive computerized education technique. This program currently is in use by other medical organizations, and has been demonstrated at an AMA educational meeting. Dr. Alessi has arranged for this program to be demonstrated at the next meeting of the AMNJ Board of Trustees. The aducation committee has been invited to attend this meeting.

J. Richard Goldstein, M.D., Commissioner of Health of New Jersey was the guest at the October "First Wednesday at the Academy" meeting. Dr. Goldstein spent 1½ hours in an intensive question-and-answer session. These small luncheon meetings are open to all members of the Academy of Medicine and their spouses. The sessions are intended to provide the opportunity for free discussion in an informal setting. A representative of the State Board of Medical Examiners was the guest at the November meeting.

At the January meeting of the Board of Trustees, the Board decided upon the recipients of the Edward J. Ill Award, and of the Citizen's Award. The recipients of these awards will be formally honored at the annual Academy dinner on May 23, 1984.

New Members

The Journal would like to welcome the following members to the Medical Society of New Jersey:

Atlantic County
Lawrence Blacher, M.D., Northfield
Raymond S. Schreyer, M.D., Pomona
Stephen H. Uretsky, M.D., Linwood

Bergen County
John T. Andronaco, M.D., Hackensack
Robert M. Bernstein, M.D., Englewood
Robert B. Ein, M.D., Westwood
Bernard Gardner, M.D., Hackensack
Donald H. Kutner, M.D., Saddle Brook
Murray H. Rothman, M.D., Rutherford
Geoffrey W. Tobias, M.D., Englewood

Burlington County
James Q. Atkinson, III, M.D., Medford
Max Burger, M.D., Medford
Joseph DeLaurentis, M.D., Mount Laurel
Jeffrey J. Kutscher, M.D., Moorestown
Mylappan Selvaraj, M.D., Browns Mills
Bruce W. Wulfsberg, M.D.

Cape May County
Warren F. MacDonald, Jr., M.D., Cape May Court House
Bruce R. Noll, M.D., Cape May Court House

Essex County
Renato C. Miguel, M.D., Paramus
Fanya Munits, M.D., Maplewood
Myles I. Rosenthal, M.D., New Providence
Lewis P. Stolman, M.D., Livingston

Gloucester County
Saroja Nadig, M.D., Woodbury

Hudson County
Ignacio A. Chiong, M.D., Union City

Mercer County
Robert B. Berger, M.D., Princeton
Steven R. Levine, M.D., Princeton
Frank P. Schinco, M.D., Trenton

Middlesex County
Pablo Bencosme, M.D, Perth Amboy
Anthony J. Chiaramida, M.D., Perth Amboy
Sheela Choubey, M.D, Piscataway
Nancy E. Gary, M.D., Piscataway
Betty L. Hammond, M.D., New Brunswick
Edward D. Harris, M.D., New Brunswick
Stuart M. Hochron, M.D., Iselin
Robert H. Rathauser, M.D., North Brunswick
Stanley E. Rich, M.D., Manalapan
Joseph P. Romano, M.D., Rahway
Kenneth D. Steiner, M.D., Woodbridge
Lawrence T. Taft, M.D., New Brunswick

Monmouth County
Gabor Barabas, M.D., Long Branch
John B. Checton, M.D, Long Branch
Paul E. Dedick, M.D., Red Bank
Danilo R. Espineli, M.D., Howell
Michael H. Flashburg, M.D., Asbury Park
Suresh C. Giri, M.D., Freehold
Jennifer L. Harper, M.D., Neptune
Michael D. Karoly, M.D., Red Bank
Amos Katz, M.D., Freehold
William I. Kohlberg, M.D., Freehold
Randall S. Krakauer, M.D., Freehold
Mary L. Krisza, M.D., West End
Alvin H. Morgenstern, M.D., Freehold
Joseph T. Nitti, M.D., Brielle
Charles B. Peeples, M.D., Long Branch
Arthur H. Phair, M.D., Red Bank
Vijayalaxmi Varadarajan, M.D., Red Bank

Morris County
Hiliary C. Brynildsen, M.D., Denville
Peter J. Brynildsen, Denville
Arthur R. Israel, M.D., Morristown
Barry K. Levin, M.D., Morris Plains
Lawrence M. Skolnick, M.D., Morristown
Andrew N. Stolzar, M.D., Dover

Passaic County
Ralph E. Caprio, M.D., Clifton
Steven R. Isaacson, M.D., Clifton
Deanna Z. Macek, M.D., Riverdale
Arnold H. Slyper, M.D., Paterson
Lawrence D. Weinstein, M.D., Pompton

Union County
Marvin J. Blumenfrucht, M.D., Elizabeth
Calvin G. Constandis, M.D., Cranford
Thomas F. Crompton, M.D., Elizabeth
Brian Donnelly, M.D., Summit
Richard L. Eichel, M.D., Elizabeth
Ralph E. Farinella, M.D., Union
Steven L. Halpern, M.D., Summit
Michael S. Lux, M.D., Summit
Donna D. Mahlstedt, M.D., Warren
Richard A. Marfuggi, M.D., Elizabeth
Erenio Mejias, M.D., Elizabeth
Kantilal Patel, M.D., Newark
Vito A. Petrozzino, M.D., Union
Adam J. Rowen, M.D., Elizabeth
Lorne B. Sheren, M.D., Summit
Donald R. Sweeney, M.D., Summit
Richard W. Tai, M.D., Union
Stuart Waldstreicher, M.D., Summit

Warren County
Eduardo C. Lomibao, M.D., Phillipsburg

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY—Jan Charles Horrow, M.D., 131 Pond Brook Rd., Chestnut Hill, MA 02167. Pennsylvania 1977. Board certified. Group, academia, HMO. Available.

CARDIOLOGY—Aubrey Orrin Lewis, M.D., 200 Carman Ave., Apt. 21-F, East Meadow, NY 11554. SUNY-Syracuse 1979. Also, general internal medicine. Board certified (IM). Solo, partnership, group, academia (cardiology). Available July 1984.

Ltc. Gary P. Schwartz, M.D., USAF, 8 Lodge Dr., Rockville, MD 20850. SUNY-Upstate 1968. Board certified. Single specialty, multispecialty group, partnership. Available September 1984.

FAMILY MEDICINE—Jaime F. Lara, M.D., 6045 Palisade Ave., West New York, NJ 07093. Seville (Spain) 1979. Board eligible. Partnership or institutionally based. Available.

David Neidorf, M.D., 1701 Taxville Rd., Apt. 7A, York, PA 17404, SUNY-Stony Brook 1981. Board certified. Group, partnership, HMO. Available August 1984.

GASTROENTEROLOGY—Albert M. Harary, M.D., 2121 N. Bayshore Dr., Apt. 1001, Miami, FL 33137. Columbia 1978. Also, general internal medicine. Board certified (IM). Group, partnership, solo. Available July 1984.

P. Kothanda Raman, M.D., 9 Lake Ave., Apt. 5A, East Brunswick, NJ 08816. Stanley Medical College (India) 1977. Board eligible (IM). Also internal medicine. Partnership, group, solo. Available July 1984.

INTERNAL MEDICINE—Harold J. Brown, M.D., 260 Eggerts Rd., Lawrenceville, NJ 08648. UMDNJ 1982. Primary care clinic, HMO, group, partnership. Available July 1985.

Elliott Friedman, M.D., 25 Penny La., Baltimore, MD 21209. SUNY-Syracuse 1978. Subspecialty, endocrinology. Board certified (IM); board eligible (endocrinology). Group or partnership (both specialties). Available July 1984.

Lee W. Hoffer, M.D., 1017 East 80th St., Brooklyn, NY 11236. Rome (Italy) 1980. Solo, partnership, group. Available.

Arvind Mehta, M.D., 8051 N. Hanover St., Anaheim, CA 92861. Seth G.S. Medical College (India) 1975. Also, nephrology. Board eligible. Solo, group, associate. Available.

P. Kothanda Raman, M.D., 9 Lake Ave., Apt. 5A, East Brunswick, NJ 0881 Stanley Medical College (India) 197 Board eligible. Also, gastroenterolog Partnership, group, solo. Available Ju 1984.

Patricia M. Romano, M.D., 1077 Riv Rd., N608, Edgewater, NJ 07020. Corn University Medical College 1979. Als pulmonary. Board certified. Group. Ava able July 1984.

Laurence M. Silverstein, M.D., 500 Av G, #7, Redondo Beach, CA 90277. Albe Einstein 1979. Board certified. Availabl

Yi-po Wu, M.D., 32 Hapgood Wa Shrewsbury, MA 01545. National Taiwa University Medical College 1972. Boar eligible. Group or partnership.

NEPHROLOGY—Arvind Mehta, M.D 8051 N. Hanover St., Anaheim, CA 92861 Seth G.S. Medical College (India) 197 Also, internal medicine. Board eligible Solo, group, partnership. Available.

NEUROLOGY—Elizabeth Kamenar, M.D. 12701 Shaker Blvd., Apt. 410, Cleveland OH 44120. Ohio State 1975. Board eligible Group, partnership, academia. Availabl July 1984.

Robert P. Rubens, M.D., 105 Ward St. Apt. 204, Seattle, WA 98109. UMDNJ New Jersey Medical School 1980. Boarc eligible. Available July 1984.

OBSTETRICS/GYNECOLOGY—Alan M Askinas, M.D., 1309 Carrollton, Apt. 321, Metairie, LA 70005. Illinois 1980. Board eligible. Group, partnership, solo, part academia. Available July 1984.

Joseph Booker, Jr., M.D., 2500 Milvia St., Apt. 228, Berkeley, CA 94704. University of California-San Francisco 1973. Partnership, group, solo. Available.

Wook Chung, M.D., 2212 Watterworth Dr., Kalamazoo, MI 49008. Catholic Medical College (Korea) 1967. Board certified. Solo, group, partnership. Available.

Iris E. Dominy, M.D., 108 Pinegate Circle, Apt. 2, Chapel Hill, NC 27514. Albany 1978. Board eligible. Partnership or group in metropolitan area. Available July 1984.

Angela McVey, M.D., 3191 Agate St., Philadelphia, PA 19134. Bucharest Medical School (Rumania) 1949. Board eligible. Group, partnership, hospital, academia. Available.

OPHTHALMOLOGY—Steven R. Davis, M.D., 1000 Lakeview Rd., Clearwater, FL 33516. University of Alabama 1975. Board certified. Solo or association. Available.

Andrew Gewirtz, M.D., 519 Beach 133 St., Belle Harbor, NY 11694. Chicago 1978. Board eligible. Board certified (pediatrics). Group or partnership. Available July 1984.

PATHOLOGY—Mark A. Grathwhol, M.D., 2510 West Tremont Ct., Richmond, VA 23225. NYU 1980. Group. Available July 1984.

PEDIATRICS—Jonathon J. Evans, M.D., 1800 Calvin Ct., #6, Iowa City, IO 52240. Univ. of California-San Diego 1981. Board eligible. Group or HMO. Available July 1984.

Howard Mintz, M.D., 60 Presidential Plaza, Apt. 308, Syracuse, NY 13202. Pittsburgh 1981. Board eligible. Group or partnership. Available July 1984.

PSYCHIATRY—Eric M. Levin, M.D., 43 West 8th St., Media, PA 19063. La Faculté Libre de Medicine (Spain) 1980. Board eligible. Group, institutionally based, CMH outpatient. Available July 1984.

PULMONARY DISEASES—James Kohan, M.D., 19 Highmanor Dr., Henrietta, NY 14467. Virginia 1979. Also, general internal medicine. Board certified (IM). Group, partnership, solo, institutional. Available July 1984.

Patricia M. Romano, M.D., 1077 River Rd., N608, Edgewater, NJ 07020. Cornell University Medical College 1979. Also, internal medicine. Board certified (1M). Group. Available July 1984.

RADIOLOGY/NUCLEAR MEDICINE—Conrad P. Erlich, M.D., 1243 Beacon St., Apt. 3B, Brookline, MA 02146. Boston 1976. Board certified. Group or partnership. Available July 1984.

Mindy M. Horrow, M.D., 131 Pond Brook Rd., Chestnut Hill, MA 02167. Med College of Pennsylvania 1980. Board eligible. Group, HMO, academia. Available.

RHEUMATOLOGY—Richard Furie, M.D., 435 E. 70th St., Apt. 8-F, New York, NY 10021. Cornell 1979. Also, general internal medicine. Board certified (IM). Group, partnership, solo. Available July 1984.

SURGERY, GENERAL—Ramon J. Gomez, M.D., 40-71 Gleane St., Elmhurst, NY 11373. University of the East (Philippines) 1978. Group or hospital-based emergency medicine practice. Available.

Ravinder Jagpal, M.D., 3408 Balboa La., Apt. 33, Columbia, MO 65201. Rutgers 1981. Also cardiothoracic surgery. Board certified (general surgery); board eligible (cardiothoracic surgery). Group. Available July 1984.

SURGERY, ORTHOPEDIC—Jeffrey H. Charen, M.D., 155 Lexington St., Apt. 15, Auburndale, MA 02166. Rochester 1978. Board eligible. Group, partnership, solo (central or northern NJ preferred). Available January 1984.

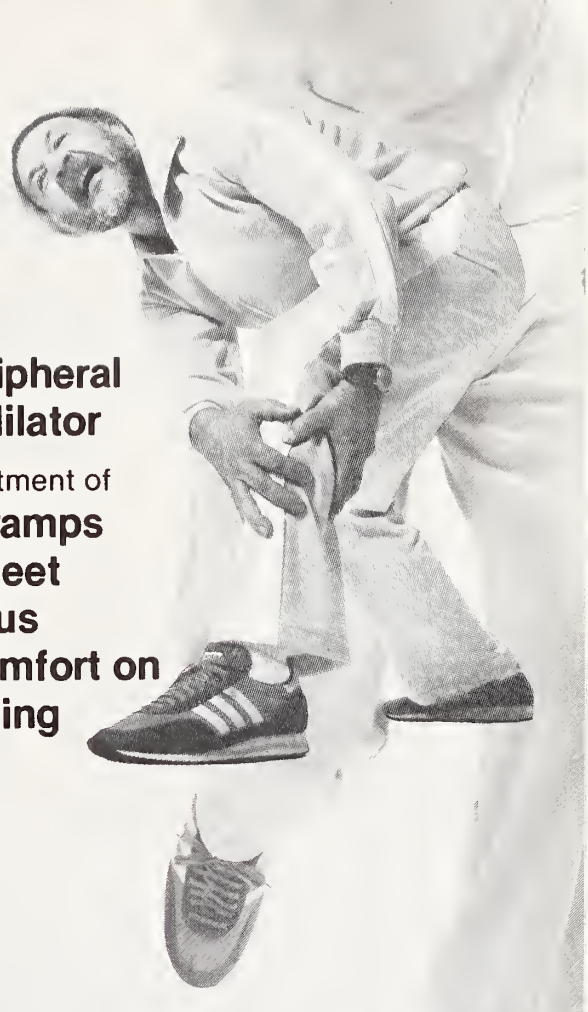
Salvatore Inserra, M.D., 1847 79th St., Brooklyn, NY 11214. NYU 1979. Board eligible. Group, partnership, solo. Available July 1984.

Richard Lebovicz, M.D., 415 Grand St., New York, NY 10002. SUNY-Downstate 1979. Group or partnership. Available July 1984.

Oscar A. Reicher, M.D., 71 Brookwood Ter., Nashville, TN 37205. Pittsburgh 1979. Solo or group. Available July 1984.

UROLOGY—Joseph G. Colonna, M.D., 1234 Van Voorhis Rd., Apt. C-6, Morgantown, WV 26505. Guadalajara (Mexico) 1977. Board eligible. Group or partnership. Available October 1984.

Barlow S. Lynch, M.D., 5145 Linda Lou Dr., Carmichael, CA 95608. SUNY-Buffalo 1977. Board eligible. Partnership, group, solo, academia. Available July 1984.



A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy



For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release
LIPO-NICIN®/300 mg.

Each time-release capsule contains:
Nicotinic Acid .....300 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release
LIPO-NICIN®/250 mg.

Each yellow tablet contains:
Nicotinic Acid .....250 mg.
Niacinamide .....75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide .....75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER PD

Housing Application

218th ANNUAL MEETING
THE MEDICAL SOCIETY OF NEW JERSEY

MAY 3-6, 1984

	Single	Twin	Suites
Resorts International (headquarters hotel)	$80.00	$80.00	$171/$250
Harrah's Marina Hotel Casino	$75.00	$75.00	
World International Hotel/Motel	$58.00	$58.00	
Lafayette Motor Inn	$58.00	$58.00	

Rates subject to 12% state and local taxes; tax subject to change.

All hotel reservations for the 218th Annual Meeting of MSNJ will be handled by the Atlantic City Convention Bureau. Please send your housing application with your 1st, 2nd, and 3rd choices directly to the Bureau, 16 Central Pier, Atlantic City, NJ 08401. All Delegates and Members are urged to make their hotel reservations early. Blocks of rooms will be available at Resorts International (headquarters hotel), Lafayette Motor Inn, World International Hotel/Motel, and Harrah's Marina Hotel Casino. The cut-off date for reservations will be April 6, 1984. Reservations cannot be guaranteed after this date. No Saturday arrivals please. All registrants will be charged for three nights: Thursday, Friday, and Saturday, May 3, 4, and 5, 1984.

MAIL THIS APPLICATION DIRECTLY TO THE ATLANTIC CITY CONVENTION BUREAU
16 Central Pier
Atlantic City, NJ 08401

Please list 1st, 2nd, and 3rd choices; confirmation will come directly from hotel.

1st Choice _____ 2nd Choice _____

3rd Choice _____

Accommodations desired: ☐ Single ☐ Twin ☐ Suite Parlor & 1 Bedroom
☐ Suite Parlor & 2 Bedrooms

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

Will arrive _____ (date) Time _____ Will depart _____ (date) Time _____

☐ Check if Official Delegate _____ County _____

MEDICAL PHILATELY

The Path to Modern Medicine

JOSEPH H. KLER, M.D., New Brunswick*

ABDOMINAL SURGERY

Theodor Billroth (1829-1894) was born in Ruegen and obtained his medical degree from the University of Berlin in 1852. In 1859, he was appointed professor of surgery at the University of Zurich, and from 1867 until his death he held a similar position at the University of Vienna. During the Franco-Prussian War (1870-1871), he served as surgeon in the military hospitals at Weissenberg and Mannheim.

In 1871, Billroth successfully performed the most extensive resection of the pharynx to date (pharynx, larynx, epiglottis, and thyroid). Also, he introduced a successful gastrorrhaphy for the cure of gastric fistula. Billroth performed the first successful gastrectomy for cancer of the pylorus on January 29, 1881. Malignant lymphoma (Billroth's disease) received his surgical appraisal as a destructive lesion with nodal recurrence. His contributions to medical literature included, *General Surgical Pathology and Therapeutics,* which went through 11 editions and was translated into many languages.

Considered one of the foremost surgeons of his time, Billroth was an authority on histology, pathology, and military surgery. A man of genial personality and strong artistic bent, he was a lifelong friend of Johannes Brahms. In 1887, Billroth was given a seat in the upper house of Parliament of Austria-



Billroth
Austria, 1937

Hungary, a distinction rarely conferred on a member of the medical profession. He had the respect and love of all Vienna. He is considered the founder of modern abdominal surgery.

DIGESTION AND CONDITIONED REFLEXES

Ivan Pavlov (1849-1936) was born in Ruazan, Russia, the son of a priest. He studied at St. Petersburg University and received his doctorate in 1883. He then studied with Heidenhain in Breslau and with Ludwig in Leipzig.

Pavlov returned to St. Petersburg and became one of the greatest physiologists of modern times. He became interested in the processes of gastric digestion and painstakingly worked out the details of the role of the autonomic nervous system. For this, Pavlov received the Nobel Prize in 1904.

However, Pavlov's most outstanding work was on "conditioned reflexes," a physiological discovery of first rank that has had a profound influence on physiology and psychology.



Pavlov
Argentina, 1949

*It is with regret that we state this will be the last column on medical philately. Dr. Kler died on November 22, 1983.

April-September 1984

#312 Tues. Eves. 4-7 p.m.

Emergency Medicine Board Review

TUITION: $795

Accreditation:

63 AMA Category 1 credit hours.

63 AAFP credit hours.

63 ACEP credit hours.

NYU

For New York metropolitan area physicians: Twenty one weekly 3-hour sessions spread over a 21 week period to prepare for the written portion (Part I) of the Emergency Medicine Board Examination, plus on a limited first-come basis two, 2-hour ("1 on 1") patient management encounters for each registrant that simulates and prepares candidates for the oral portion (Part II) of the Board Examinations.

Information available on #315 EMERGENCY MEDICINE, June 18-22, 1984, Monday-Friday

FOR FURTHER INFORMATION: NYU Post-Graduate Medical School, 550 First Avenue, New York, NY 10016 (212) 340-5295 (24 Hour Service)

LIKOFF CARDIOVASCULAR INSTITUTE

of Hahnemann Medical College & Hospital

230 N. Broad Street, Philadelphia, Pennsylvania 19102 (215) 448-8063

CARDIOLOGY UPDATE. . .

IS DESIGNED FOR THE PHYSICIAN AND PROVIDES AN INTENSIVE SURVEY OF THE CURRENT STATUS OF CLINICAL CARDIOLOGY. . .

WEDNESDAY, FEBRUARY 1, 1984

CARDIOMYOPATHY

MODERATOR: BERNARD L. SEGAL, M.D.

3:00	CASE PRESENTATION	*Edward Catherwood, M.D.*
3:30	THE CLINICAL, ECHOCARDIOGRAPHIC, VENTRICULOGRAPHIC DIAGNOSIS OF HYPERTROPHIC CARDIOMYOPATHY	*Gary S. Mintz, M.D.*
4:00	THE REST AND EXERCISE ELECTROCARDIOGRAM AND HOLTER MONITORING IN PATIENTS WITH HYPERTROPHIC CARDIOMYOPATHY	*A-Hamid Hakki, M.D.*
4:30	MEDICAL AND SURGICAL MANAGEMENT/RISK AND BENEFIT	*Morris N. Kotler, M.D.*
5:00	NEW ADVANCES IN CORONARY ANGIOPLASTY	*Demetrios Kimbiris, M.D.*
5:30	PANEL DISCUSSION	

LECTURE HALL "A"—2nd floor New College Building, Hahnemann University
15th and Vine Streets, Philadelphia, PA

• NO REGISTRATION FEE • NO ADVANCE REGISTRATION REQUIRED •
• CME CATEGORY I CREDITS CERTIFIED •
WINE & CHEESE SERVED FOLLOWING CONFERENCE

CME CALENDAR

This list is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the University of Medicine and Dentistry. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

Feb.

11 **Clinical Anesthesia 1984**
8 a.m.-3:50 p.m.—UMDNJ-New Jersey Medical School, Newark
(UMDNJ)

Mar.

9 **25th Postgraduate Anesthesia Seminar**
10 8 a.m.—Hyatt, Cherry Hill
11 *(NJ State Society of Anesthesiologists and AMNJ)*

CARDIOLOGY

Feb.

16 **Pathophysiology and Management of Angina Pectoris**
5-6:30 p.m.—Somerset Medical Center, Somerville
(Somerset Medical Center)

Mar.

7 **Noninvasive Testing in Cardiovascular Disease**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Middlesex General Hospital and AMNJ)

7 **Cardiology**
14 3-6 p.m.—Overlook Hospital, Summit
21 *(Overlook Hospital and AMNJ)*

20 **Current Therapy of Acute Myocardial Infarction**
12 noon—St. Mary's Hospital, Orange
(AMNJ)

MEDICINE

Feb.

1 **Endocrinology Series-Medical Grand Rounds**
11:30 a.m.—VA Medical Center, East Orange
2 9:30 a.m.—Newark Beth Israel Medical Center, Newark
3 11:30 a.m.—UMDNJ-University Hospital, Newark
(Endocrinology Section, AMNJ)

1 **Endocrine Conference**
8 3:30-5 p.m.—Rotates between Newark
15 Beth Israel Medical Center, University
22 Hospital, United Hospitals Medical
29 Center, Newark, and VA Medical Center, East Orange
(Endocrinology Section, AMNJ)

1 **Newer Insulins**
8 **Congenital Pulmonary Anomalies**
1-2:30 p.m.—Christ Hospital, Jersey City
(Christ Hospital)

1 **Diagnosis and Treatment of Incontinence in Geriatric Patients**
1:30 p.m.—Essex County Hospital Center, Cedar Grove
(Essex County Hospital Center)

1 **CDS Prescribing Practices**
11 a.m.-12 noon—Morristown Memorial Hospital
(AMNJ)

1 **Gastroenterology**
15 **Pulmonary**
22 **Pulmonary**
3-6 p.m.—Overlook Hospital, Summit
(Overlook Hospital and AMNJ)

1 **Lung Cancer**
8 **Breast Cancer**
15 **Sickle Cell Anemia**
22 **Chronic Lymphocytic Leukemia**
29 **Metabolic Renal Stone Disease**
8-9 a.m.—Alexian Brothers Hospital, Elizabeth
(Alexian Brothers Hospital and AMNJ)

1 **Hodgkins and Non-Hodgkins Lymphoma**
8 **Urological Cancer**
15 **Hematologic Emergencies**
22 **Colon Cancer**
29 **Burn Assessment and Emergency Treatment**
9-10 a.m.—Alexian Brothers Hospital, Elizabeth
(Alexian Brothers Hospital and AMNJ)

2 **The Current Status of Antiviral Chemotherapy**
11 a.m.-12:30 p.m.—St. Joseph's Hospital and Medical Center, Paterson
(St. Joseph's Hospital and Medical Center)

3 **Renal Conference in Nephrology**
17 4-5 p.m.—UMDNJ-University Hospital, Newark
(Nephrology Society of NJ, Nephrology Section, and AMNJ)

7 **Geratrics-Medication Prescribing Practices**

21 **Hypertension-Malignant**
11-12 noon—Greystone Park Psychiatric Hospital, Greystone Park
(Greystone Park Psychiatric Hospital)

9 **Diagnosis and Treatment of Multiple Sclerosis**
11 a.m.—St. Joseph's Hospital and Medical Center, Paterson
(UMDNJ and St. Joseph's Hospital)

15 **Rutgers Dermatological Conference**
6-9 p.m.—Rutgers Community Health Plan, 57 U.S. Hwy. 1, New Brunswick
(UMDNJ and AMNJ)

17 **Management of Portal Hypertension**
8-9:30 a.m.—Overlook Hospital, Summit
(Overlook Hospital)

21 **Nephrotoxicity-1984: An Update**
4-5 p.m.—Academic Health Service Center, New Brunswick
(UMDNJ)

21 **Prevention and Treatment of Decubitus Ulcers**
12 noon—St. Mary's Hospital, Orange
(St. Mary's Hospital)

21 **Sodium Homeostasis in Liver Disease**
7-8 p.m.—Ramada Inn, Clark
(Nephrology Society of New Jersey)

22 **Pulmonary Function Tests and Emphysema**
10:30-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital)

22 **Renal Hypertension or HPN Secondary to Kidney Disease**
1:00 to 2:30 p.m.—VA Medical Center, Lyons
(Veterans Administration Medical Center)

29 **Evaluation and Treatment of Occupational and Environmental Lung Disease**
9-11 a.m.—Middlesex General-University Hospital, New Brunswick
(Middlesex General-University Hospital)

29 **Ophthalmology Associated with Systemic Diseases**
10:30-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital)

Mar.

1 **Medical Grand Rounds**
9:30 a.m.—Newark Beth Israel Medical Ctr.
(Endocrinology Section, AMNJ)

1 **Effects of Stress on Disease**
15 **Heart Disease, Lipoproteins, and Nutritional Counseling**
11 a.m.—St. Joseph's Hospital and Medical Center, Paterson
(St. Joseph's Hospital and UMDNJ)

2 **Medical Grand Rounds**
11:30 a.m.—University Hospital, Newark
(Endocrinology Section, AMNJ)

2 **Renal Conferences in Nephrology**
16 4-5 p.m.—UMDNJ-University Hospital, Newark
(Nephrology Society of NJ and Nephrology Section, AMNJ)

6 **Nutrition Support—Middle Age and the**

WE NEED YOUR ASSISTANCE!

The Treatment Loan Fund of
the Impaired Physicians Program

Our impaired colleagues often are financially impaired in addition to their major impairment. MSNJ has set up a loan fund to assist these physicians with low interest loans in meeting the costs of treatment and/or family support during their time away from their practice in treatment.

The Board of Trustees of MSNJ has authorized this ad to solicit **voluntary contributions** from our membership to this fund. We have begun solicitation of the New Jersey pharmaceutical houses and to date we have received contributions from Warner Lambert; Sandoz; Merck; American Home Products; and Squibb.

A common question in soliciting contributions from outside source is "What are the doctors doing?" Your assistance will aid our impaired colleagues and improve our outside returns.

Please send you contributions to: **Impaired Physicians Program Treatment Loan Fund, Medical Society of New Jersey, 2 Princess Road, Lawrenceville, NJ 08648.**

ACUPUNCTURE IN CLINICAL PRACTICE

N.Y. State Boards of Medicine & Dentistry 25-hour accredited seminar and workshop on the latest theories & techniques of manual and electro-acupuncture, applicable toward the 200-hour requirement for certification, will be given for licensed clinicians (with or without prior training) during the weekend of January 27-29, 1984 and again the weekend of March 23-25, 1984 at the Barbizon Plaza Hotel, New York City. Co-sponsored by the International College of Acupuncture & Electro-Therapeutics, its official journal (published by Pergamon Press) the Heart Disease Research Foundation and the Neuroscience Dept. of Long Island College Hospital, Pharamcology Dept. of The Chicago Medical School. Also eligible for AMA/CME credit. For information, contact Y. Omura, M.D., ScD., 800 Riverside Drive (8-1), NYC 10032. Tel: (212) 781-6262 or (212) WA8-0658, or Saul Heller, M.D., Tel: (212) 838-7514.

NYU MEDICAL CENTER

Post-Graduate Medical School

January

1/4-6/20 Internal Medicine Board Review, Wednesdays, 4-7 PM

March

12-16 Managing Clinical Problems in the Elderly (Cerromar Beach Hotel/Puerto Rico)

19-23 Seminar in Advanced Rheumatology

26-30 Anesthesiology: Comprehensive Review III

April

26-28 Update in Clinical Dermatology

Information: Mary Ann Giammarino, NYU Post-Graduate Medical School, 550 First Avenue, New York, NY 10016 (212) 340-5295.

CONTRACEPTION TODAY

Improving the Results—Reducing the Concerns
March 31-April 1, 1984

SCANTICON-PRINCETON CONFERENCE CENTER
PRINCETON, NEW JERSEY

Topics Include: Improving Contraceptive Utilization • Managing Common Complaints • Risks • Detection of Contraceptive Failure • Legal Aspects of Providing Contraception.

Inquiries: Patricia Reid, UMDNJ-Rutgers Medical School, Box 101, Piscataway, NJ 08854 (201) 463-4707

CHRONIC DISORDERS IN PEDIATRICS: New Approaches to Old Problems

March 21, 22, 1984

Central Nervous System Trauma
Chronic Respiratory Disorders
Kinesthetic Disorders
Birth Defects

The Madison Hotel
Convent Station, New Jersey

Sponsored by:

CHILDREN'S SPECIALIZED HOSPITAL
New Providence Road
Mountainside, New Jersey 07091

for more information call:

Sallie Comey
Education Coordinator
(201) 233-3720

NEW YORK FERTILITY RESEARCH FOUNDATION, INC.

For the Investigation of
Problems of Human Infertility

The Foundation provides a complete diagnostic and consultation service for infertile couples. Investigations are conducted by well-known specialists in conjunction with consultants in the various fields of medicine related to infertility.

The Foundation is supported by an in-house modern laboratory equipped to do most tests required for diagnosis and treatment. Literature on request.

1430 Second Avenue, Suite 103
New York, N.Y. 10021
Phone: (212) 744-5500

Elderly
11 a.m.-12 noon—Greystone Park Psychiatric Hospital
(AMNJ)

7 **Medical Grand Rounds**
11:30 a.m.—VA Medical Ctr., East Orange
(Endocrinology Section, AMNJ)

7 **Hypertension**
1:30 p.m.—Essex County Hospital Ctr., Cedar Grove
(AMNJ)

7 **Angina**
21 **Obstructive Uropathy**
1-2:30 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

7 **Endocrine Conferences**
14 3:30-5 p.m.—Rotates between Newark
21 Beth Israel Medical Ctr., UMDNJ-
28 University Hospital, Newark, VA Medical Ctr., East Orange, and United Hospitals Medical Ctr., Newark
(Endocrinology Section, AMNJ)

8 **Pain Therapy**
2 p.m.—John E. Runnells Hospital of Union County, Berkeley Heights
(AMNJ)

13 **Diet and Cancer**
22 **Detection and Diagnosis**
29 **Principles of Patient Management**
4-6 p.m.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

15 **Current Approaches to Irritable Bowel Syndrome**
5-6:30 p.m.—Somerset Medical Ctr., Somerville
(Somerset Medical Center and AMNJ)

20 **Emergency Care—Cardiac Drug Overdose**
11 a.m.-12 noon—Greystone Park Psychiatric Hospital
(AMNJ)

20 **Hypertension**
1:30-2:30 p.m.—Essex County Hospital, Cedar Grove
(AMNJ)

20 **Regional Nephrology Conferences**
4-5 p.m.—Academic Health Science Ctr.
(UMDNJ-Rutgers Medical School and AMNJ)

21 **Dermatological Conference**
6-9 p.m.—Rutgers Community Health Plan, 57 U.S. Hwy. 1, New Brunswick
(UMDNJ-Rutgers Medical School and AMNJ)

21 **Significance and Treatment of Common Abnormalities in Serum Electrolytes and/or Acid-Base Balance**

28 **Antibiotic and Antiviral Agents in an Office Practice**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Middlesex General Hospital and AMNJ)

28 **Extended Spectrum Penicillin and Cephalosporins**
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

28 **Implications of Clinical Trials on Management of Mild Hypertension**
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

28 **Dermatology**
3-6 p.m.—Overlook Hospital, Summit
(Overlook Hospital and AMNJ)

218th Annual Meeting
May 2-6, 1984

Resorts International
Atlantic City, New Jersey

Daily Schedule

Wednesday, May 2, 1984
3:30 p.m.—Board of Trustees' Meeting
7:00 p.m.—Officers' Cocktail Reception followed by Dinner

Thursday, May 3, 1984
9:00 a.m.—Registration Opens
2:00 p.m.—House of Delegates
4:00 p.m.—Reference Committees (Three Reference Committee Meetings)

Friday, May 4, 1984
7:30 a.m.—Registration Opens
9:00 a.m.—House of Delegates (election)
9:00 a.m.—Message Center, and Scientific, Informational, and Insurance Exhibits Open
12:00 noon—Golden Merit Award Ceremony followed by Reception
2:30 p.m.—Reference Committees (Three Reference Committee Meetings)
5:00 p.m.—JEMPAC Political Forum
5:45 p.m.—JEMPAC Wine & Cheese Reception

Saturday, May 5, 1984
8:00 a.m.—Registration Opens
9:00 a.m.—Message Center, and Scientific, Informational, and Insurance Exhibits Open
9:00 a.m.—Scientific Sessions
12:00 noon—Luncheons
1:00 p.m.—Scientific Sessions
6:30 p.m.—Inaugural Reception followed by Inaugural Dinner

Sunday, May 6, 1984
6:30 a.m.—County Society Breakfast Caucuses
8:00 a.m.—Registration Opens
9:00 a.m.—Message Center, and Scientific, Informational, and Insurance Exhibits Open
9:00 a.m.—House of Delegates
3:00 p.m.—Board of Trustees' Meeting

NEUROLOGY/PSYCHIATRY

Feb.

1 **Psychopharmacology**
2-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(Ancora Psychiatric Hospital and AMNJ)

2 **Benzodiazepines in the 1980s**
16 **Suicide Assessment**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

9 **The New Pathogens**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

15 **Group Therapy**
29 2-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(Ancora Psychiatric Hospital and AMNJ)

16 **Spirit, Psyche, Religion, and Psychopathology**
12 noon-4:30 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

29 **Neurology**
3-6 p.m.—Overlook Hospital, Summit
(Overlook Hospital and AMNJ)

Mar.

1 **Pharmacotherapeutic Agents in the Management of Borderline-Personality Disorders**

8 **Advances in Neuroleptic Medication**
15 **Alone—Yearning for Companionship**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

6 **Is There a Devil?**
8:15-10:30 p.m.—39 Crescent Ave., Passaic
(Essex Psychiatric Seminar and AMNJ)

7 **Group Therapy**

21 2-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(Ancora Psychiatric Hospital and AMNJ)

14 **Anxiety and Neurosis**
9-11 a.m.—Middlesex General Hospital, New Brunswick
(Middlesex General Hospital and AMNJ)

15 **Aspects of Anorexia Nervosa**
8-10 p.m.—Hackensack Hospital
(NJ Psychoanalytic Society and AMNJ)

19 **Principles of Child Psychotherapy**
8:30-10:30 p.m.—Office of Dr. Deutsch, 301 Broad St., Englewood
(NJ Psychoanalytic Society and AMNJ)

21 **Tardive Dyskinesia and Other Movement Disorders**
9 a.m.-4:45 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

OBSTETRICS/GYNECOLOGY

Feb.

1 **Amenorrhea**
9-11 a.m.—Middlesex General-University Hospital, New Brunswick
(Middlesex General-University Hospital)

1 **Laparoscopy, Colposcopy, Infertility**
10:30-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital)

2 **Fetal Visualization of Prenatal Diagnosis**
9:00 a.m.—Freehold Area Hospital, Freehold
(Freehold Area Hospital)

Mar.

31 **Contraception Today**
9 a.m.-5 p.m.—Princeton Scanticon Conference Ctr., Princeton
(UMDNJ-Rutgers Medical School and AMNJ)

PATHOLOGY

Feb.

2 **Macrophages and Their Relations to Neoplasia**

9 **Natural Killer Cells**

16 **Cell-Mediated Immunity and Regulatory Cells**

23 **Tumor Protective and Facilitating Antigens**
4-6 p.m.—Institute for Medical Research, Camden
(Institute for Medical Research)

8 **Pathology Grand Rounds**
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital)

Mar.

1 **Biology of Immune Complexes in Cancer**

8 **Epidemiology of Cancer: An Overview**
4-6 p.m.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

14 **Pathology Grand Rounds**
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

21 **Pathology Slide Seminar/New Procedure Update**
7-9 p.m.—Hyatt House, Cherry Hill
(South Jersey Pathology Society and AMNJ)

PEDIATRICS

Mar.

1 **The Mouth and Teeth in Pediatric Practice**
9 a.m.—Freehold Area Hospital
(AMNJ)

19 **Pediatric Lecture Series**
12 noon-1 p.m.—The Mountainside Hospital, Montclair
(The Mountainside Hospital and AMNJ)

21 **Chronic Disorders in Pediatrics:**

22 **New Approaches to Old Problems**
8 a.m.-4 p.m.—Madison Hotel, Convent Station
(Children's Specialized Hospital)

23 **Diagnosis and Management of the Various Forms of Rickets**
8-9:30 a.m.—Overlook Hospital, Summit
(Overlook Hospital and AMNJ)

PSYCHIATRY

Feb.

3 **Psychiatric Aspects Concerning the Prevention of Nuclear War**
8:30-10:30 p.m.—The Atrium West, West Orange
(New Jersey Psychiatric Association)

6 **Anorexia in a Professional Woman**
8:15-10:30 p.m.—Office of Rita Newman, M.D., 543 Park St., Upper Montclair
(Essex Psychiatric Seminar)

8 **Muscle Weakness-Approach to Diagnosis and Treatment**

22 **Fits and Faints**
9-11 a.m.—Middlesex General-University Hospital, New Brunswick
(Middlesex General-University Hospital)

15 **Sleep Onset Insomnia: Assessment and Clinical Management**
1-2:30 p.m.—Christ Hospital Jersey City
(Christ Hospital)

15 **Treatment of the Agitated Elderly Patient**
1:00 to 2:30 p.m.—VA Medical Center, Lyons
(Veterans Administration Medical Center)

20 **Principles of Child Psychotherapy**
8:30-10:30 p.m.—Office of Lawrence Deutsch, M.D., Englewood
(New Jersey Psychoanalytic Society)

RADIOLOGY

Feb.

8 **Radiology**
3-6 p.m.—Overlook Hospital, Summit
(Overlook Hospital and AMNJ)

16 **Radiology Meeting**
7:30-10 p.m.—St. Barnabas Medical Center, Livingston
(Radiological Society of NJ, Radiology Section, and AMNJ)

Mar.

16 **Radiology Meeting**
7:30-10 p.m.—St. Barnabas Medical Center, Livingston
(Radiological Society of NJ and Radiological Section, AMNJ)

21 **Dinner Meeting**
6:30 p.m.—The Manor, West Orange
(Radiotherapy Section, AMNJ)

SURGERY

Feb.

1 **Surgical Departmental Conferences**

8 8:30-10 a.m.—Medical Education Bldg.,

15 Rutgers Medical School,

22 New Brunswick

29 *(UMDNJ)*

15 **Thyroid, Parathyroid Surgery**
10:30-12 noon—St. Mary's Hospital, Passiac
(St. Mary's Hospital)

Mar.

4 **Use of Appropriate Antibiotics in Surgery**
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

7 **Diagnosis and Surgical Management of Esophageal Reflux and Hiatus Hernia**
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

7 **Surgical Departmental Conference**

14 8:30-10 a.m.—Rutgers Medical School,

21 Medical Education Bldg.

28 *(UMDNJ-Rutgers Medical School)*

SURGICAL SPECIALTIES

Feb.

2 **Vascular Surgical Rounds**

9 4-5 p.m.—Rutgers Medical School,

16 New Brunswick

23 *(UMDNJ)*

15 **When and Why To Replace Which Joint-An Update**
9-11 a.m.—Middlesex General-University Hospital, New Brunswick
(Middlesex General-University Hospital)

Mar.

1 **Vascular Surgical Rounds**

8 4-5 p.m.—Rutgers Medical School,

15 Medical Education Bldg.

22 *(UMDNJ-Rutgers Medical School)*

29

6 **Surgical Management of Benign and Malignant Disease of the Breast**
7:30 p.m.—Burdette Tomlin Memorial Hospital, Cape May Court House
(AMNJ)

MISCELLANEOUS

Mar.

Clinicolegal Correspondence Course Self-Instruction-Contact Medical Inter-Insurance Exchange
(Medical Inter-Insurance Exchange of NJ and AMNJ)

LETTERS TO THE EDITOR

Vocal Cord Paralysis

October 17, 1983

Dear Dr. Knosnick:

I am writing in reference to a case report in the October 1983 issue of *The Journal.* A case of vocal cord paralysis in a benign histological disease certainly is interesting and worth reporting. Fibrosing mediastinitis certainly is rare and interesting enough as well. Although the article is entitled, "Temporary Vocal Cord Paralysis," there is no evidence that the vocal cord indeed truly recovered. The fact that the patient was free of hoarseness seven weeks later probably meant that the opposite vocal cord compensated for the left vocal cord paralysis or the left vocal cord migrated to the midline. Those of us who do or who are familiar with thyroid surgery are quite familiar with this happening. A simple mirror indirect laryngoscopy postoperatively may have been done and inadvertently unreported. This clinical finding would have been more in keeping with the title of the case report.

(signed) Lawrence J. Pizzo, M.D.

Phimosis: A Cause of Renal Failure

October 25, 1983

Dear Doctor Krosnick:

My congratulations to Joel W. Rosenberg, M.D., for his excellent article in the October 1983 issue of *The Journal* entitled, "Phimosis: A Cause of Renal Failure." His emphasis on the plethora of articles in the lay and pediatric literature objecting to circumcision is a point well taken and may lead to increased susceptibility, as mentioned, to venereal disease, malignancy, local inflammatory conditions, paraphimosis, urinary retention, and recurrent verruca of the foreskin.

These conditions occur not only in the young, but also in those of advanced years. I would like to mention a black man, age 102 years, who was admitted to Ancora State Hospital a few years ago with a diagnosis of chronic brain syndrome. He was seen in consultation because of incontinence during the day and at night. He was extremely lethargic and had a markedly elevated BUN. Examination of the penis revealed a markedly redundant foreskin with a pinpoint opening. He would urinate into the foreskin and then would drip urine constantly. He had a history of working on his farm in Salem County the previous summer and had married three times; each of his wives had died. Circumcision was performed, with return of the BUN to normal and complete clearing of his sensorium.

In selected cases where there is difficulty retracting the foreskin easily, circumcision is mandatory. In proper hands, circumcision is a relatively simple operation with lasting beneficial results.

(signed) Stanley J. Okulicz, M.D.

OBITUARIES

Dr. George E. Barbour

George Edgar Barbour, M.D., a physician at Somerset Medical Center, Somerville, for over 50 years, died on October 28, 1983. Born in 1903, Dr. Barbour earned his medical degree at the University of Pennsylvania Medical School in 1928. A surgeon, Dr. Barbour was a member of our Somerset County component and of the American Medical Association. Dr. Barbour was the recipient of MSNJ's Golden Merit Award for his years of service to the medical community.

Dr. Herman H. Goldstein

A retired member of our Union County component, Herman Harold Goldstein, M.D., died on September 30, 1983. Born in 1902, Dr. Goldstein received his medical degree from Yale University School of Medicine, Connecticut, in 1927. A urologist, Dr. Goldstein was affiliated with Newark Beth Israel Medical Center, St. Elizabeth Hospital, and Alexian Brothers Hospital, both in Elizabeth. A member of the American Medical Association, Dr. Goldstein was a Fellow of the American College of Surgeons, a Fellow of the International College of Surgeons, and a Diplomate of the American Board of Urology.

Dr. Louis F. Marrella

Louis Frank Marrella, M.D., former director of the NYSA-ILA Medical Center, Hoboken, died on October 3, 1983. Born in 1911, Dr. Marrella earned his medical degree from Loyola Medical School, Illinois, in 1940. Dr. Marrella was a member of our Hudson County component and of the American Medical Association and was a Fellow of the American Academy of Family Practice. During his career, Dr. Marrella was affiliated with Jersey City Medical Center and Christ Hospital, Jersey City.

Dr. Martin M. Meehan

At the grand age of 87, Martin Matthew Meehan, M.D., died on October 27, 1983. Dr. Meehan received his medical degree from the University of Vermont College of Medicine in 1925. During his lengthy career, Dr. Meehan was affiliated with St. Mary Hospital, Passaic. Dr. Meehan was a recipient of MSNJ's Golden Merit Award for 50 years of service to his community. A retired member of our Essex County component, Dr. Meehan was a member of the American Medical Association.

Dr. Alexander E. Schefrin

Alexander Eugene Schefrin, M.D., died on October 16, 1983. Born in 1904, Dr. Schefrin received his medical degree from Long Island College of Medicine, New York, in 1928. A pediatrician, Dr. Schefrin was affiliated with General Hospital and Beth Israel Hospital, both in Passaic. Dr. Schefrin was a member of our Passaic County component and of the American Medical Association; he was a Diplomate of the American Board of Pediatrics and a Fellow of the American Academy of Pediatrics. In 1978, Dr. Schefrin was the recipient of MSNJ's Golden Merit Award for 50 years of medical service.

Dr. Eugene W.R. Sims

At the age of 62, Eugene W. Rockfeller Sims, M.D., died on October 26, 1983. Dr. Sims earned his medical degree at Meharry Medical College, Tennessee, in 1945, and then established a family practice in East Orange in 1947. Dr. Sims served as federal aviation administration examiner and as medical director for the Essex County Department of Corrections; also, he was medical director of the Armed Forces Examining Center in Newark. Dr. Sims was a member of our Essex County component and of the American Medical Association. Dr. Sims was the first air surgeon for the New Jersey Air National Guard. He received the Col. Vance H. Marchbanks Award of the National Medical Association and the Air National Guard Meritorious Service Award for his contributions to military medicine.

Dr. Joseph G. Varhol

A member of our Passaic County component, Joseph Gregory Varhol, M.D., died on October 1, 1983. Born in 1917, Dr. Varhol received his medical degree from the University of Maryland School of Medicine in 1943. During his career, Dr. Varhol was affiliated with General Hospital, Passaic, where he was the president of its medical staff in 1967 and director of the department of anesthesia. Dr. Varhol was a member of the American Medical Association and a Fellow of the American College of Anesthesiologists.

Dr. Don B. Weems, Sr.

At the age of 81, Don Bright Weems, Sr., M.D., died on October 15, 1983, after a long illness. Dr. Weems earned his medical degree at Jefferson Medical College, Pennsylvania, in 1930. A member of our Gloucester County component, Dr. Weems was affiliated with Underwood Memorial Hospital, Woodbury. Dr. Weems was a family practitioner; he was a member of the American Medical Association. In 1981, Dr. Weems received MSNJ's Golden Merit Award for 50 years of medical service to his community.

Dr. William L. Weintraub

At the age of 82, William Louis Weintraub, M.D. died on September 30, 1983. Dr. Weintraub earned his medical degree at Bellevue Hospital Medical College, New York, in 1923. During his lengthy career, Dr. Weintraub was affiliated with Barnert Memorial Hospital Center, Paterson, Chilton Memorial Hospital, Pompton Plains, St. Joseph's Hospital and Medical Center, Paterson, and two Passaic Hospitals, Saint Mary's Hospital and Beth Israel Hospital. In 1973, Weintraub was the recipient of MSNJ's Golden Merit Award for 50 years of service as a physician.

BOOK REVIEWS

Clinical Gastroenterology. A Problem-Oriented Approach

Sidney Cohen, M.D. New York, NY, John Wiley & Sons, Inc., 1983. Pp. 464. ($25)

I commend the editor for a good and useful book. The authors are recognized experts and many already have appeared in large disease-oriented standard textbooks. This book is designed for primary care physicians and general internists who frequently need practical help with gastrointestinal (GI) patients.

The book is organized by specific clinical problems that may be seen daily by practicing physicians. The editor found that some of the topics would be better handled as specific disease entities, with clinical problems discussed in the text. He succeeded in keeping the inevitable duplication to an admirable minimum. There are 18 chapters grouped in four parts; i.e. main presentations of GI disease, specific GI condition, GI cancer, and hepatobiliary disease.

There are very few illustrations, but the tables and algorithms are very useful as is the index. I missed the pictures, but appreciated the resultant economies. The book succeeds as an aid to the practicing generalist and will be read with profit by many gastroenterologists as well.

Norman Riegel, M.D.

Current Surgical Diagnosis & Treatment, Sixth Edition

Lawrence W. Way, M.D., (ed). Los Altos, CA, Lange Medical Publications, 1983. Pp. 1221. Illustrated. ($28)

This new book is a most fitting memorial edition to Dr. J. Engelbert Dunphy, formerly professor of surgery emeritus, University of California School of Medicine, San Francisco, who was associated with its concept.

The material is up to date; the book is revised biennially. The text is very complete, stressing the broad surgical diagnostic and therapeutic aspects of surgery.

Art work and photography are excellent and helpful. Indexing is sensible and accurate. Well-selected references are provided throughout.

Subjects included in the text include major areas such as anesthesiology, wound healing, cancer chemotherapy, transplantation, and diseases of individual organs.

It is a pleasure to recommend the text to all associated with the care of surgical patients, be they medical students, clinicians, or academicians. The editors, contributors, and publishers certainly have provided, as planned, concise, up-to-date information about surgery.

The text is printed on good paper and with clear type. Its cover is soft. Attesting to the value of the material in the book is the fact that it is published in many foreign languages.

Robert K. Spiro, M.D.

Heart, Multiple Imaging Procedures

Florencio A. Hipona, M.D., (ed). New York, NY, Grune & Stratton, 1983. Pp. 241.

This book is one of a series in imaging procedures of various systems. Well-known radiologists contributed chapters covering the various imaging diagnostic modalities used to study the heart. There are discussions on cineangiocardiography, echocardiography, nuclear cardiology, and other new diagnostic modalities.

The chapters on axial cineangiography, congenital heart disease, and coronary artery disease are very well done and will be of great interest to those physicians doing cardioangiography. Two-dimensional echocardiography also is well discussed and in great detail and is worth the price of this book.

However, the chapters on dynamic chest roentgenography (kymography), ^{99m}technetium pyrophosphate myocardial infarct scanning, and cardiac computed tomography practically could have been omitted. There is no discussion at all about the great potential of nuclear magnetic resonance in cardiac imaging.

There are enough topics that will interest cardiac radiologists and cardiologists to make this a worthwhile book to peruse.

Heart, Multiple Imaging Procedures is not, however, a book that is the definitive work in the field.

Sidney Ketyer, M.D.

Manual of Clinical Gastroenterology

Gail L. Bongiovanni, M.D. New York, NY, McGraw-Hill Book Company, 1983. Pp. 581. ($15.95)

This is one of a series of manuals about clinical medicine designed for an audience of medical trainees, clinical clerks, and house officers.

The subject, gastroenterology, is subdivided into 19 chapters, each written in a terse outline form and an appendix about signs and symptoms of GI disease. The first two chapters are generalized, about pain and GI bleeding, and together with the appendix would be useful to a young clinician, especially at night when confronted by a critically ill patient.

Each topic is covered in only two or three pages or less and a recent bibliography refers the interested reader to more information. I found the index too short, but the trainee probably will use the table of contents as a guide. The experienced specialist will disagree at numerous minor points, but will agree with almost all of the presentations. I especially liked the tables and algorithms.

The authors are all fellows or assistant professors at Columbia and Harvard; however, the material is all so basic that

regionalism does not intrude and these are the words of the front liners about up-to-date use and interpretation of tests and current treatments. For those in training and for many generalists, this manual would be very useful for navigation on a stormy night at the hospital.

Norman Riegel, M.D.

The Social Transformation of American Medicine

Paul Starr. New York, NY, Basic Books, Inc., 1982. Pp. 514. ($24.95)

The Social Transformation of American Medicine is a book that should be read by every physician. In spite of its harsh words and, at times, abrasiveness toward doctors, it reveals how our profession attained its present status. Paul Starr's basic thesis seems to be that doctors have created a sovereignty which is beginning to erode through fragmentation into specialties, industrialization, exploitation by corporations, and capitulation to bureaucracy. Many facts and figures are presented to support this view. Statistics can be boring but, I assure you, this book is not as dull as its title. It more properly could be called a bible of American medicine, and could be divided into the historical books, a hospital book, a public health book, a book on medical economics, books on health insurance, a book on medical schools, a book on third parties, and a book on competition.

The author is a sociologist and looks at doctors through the eyes of a social activist. More than once he brings out that our cultural authority becomes converted into economic power and political influence. He speaks of the essence of our achievement being the ability to see social interests defined so as to conform with our own interests.

This book often is eloquent, with many quotable passages. For example, the dean who exclaimed, "It's easier to move a cemetery than to change a curriculum." It speaks of postwar America as being "a society which believed it had solved life's most serious problems, except what to do with one's spare time." The author recalls Everett Hughes's definition of quacks as "practitioners who continue to please their customers but not their colleagues." In two pages, the book describes the three types of medical benefits (indemnity, service, and direct) better than the much-discussed report "D" of the AMA's Council on Medical Services distributed at the annual meeting in June 1983.

No one involved in health care is neglected: specialists ("The specialist typically gives up those services offering the lowest return and concentrates on those offering the highest." "Specialty incomes vary directly with the percentage of work reimbursed by third parties."); pharmacologists ("Between 1900 and 1910, three changes enabled the medical profession to wrest control of the flow of pharmaceutical information"); general practitioners ("Medicine is so large now that a doctor doesn't feel confident unless he knows at least one field extremely well, rather than a little about all subjects"); physicians in group practice ("Does it mean that the family physician is being replaced by a corporation?"); medical school professors ("It is inconceivable that the university would try to carry out a policy contrary to the wishes of the department chairmen of the medical school and damned difficult for the hospital to carry out a policy contrary to the wishes of the chiefs"); entrepreneurs "(Who deprive both private doctors and local voluntary hospitals of their traditional autonomy"); doctors in politics ("In the past, decisions on health care delivery were largely professional ones. Now the decisions will be largely political"); hospital trustees ("Must increasingly exercise the authority conveyed to them by law to supervise their medical staffs."); and even those who wish to care for themselves ("Courts view the doctor-patient relationship as a partnership in decision making rather than a doctors' monopoly.").

By the time you finish this book, your intellectual wheels will be spinning. There is an adequate index and painstaking notes.

The big questions asked by the author (and to be answered in time) remain: How do we as physicians retain our autonomy and not lose control? How do we handle the new forces which threaten to reduce the sovereignty that private doctors have long exercised over medical care? In spite of feeling that "doctors continue to hold strategic positions through their established relations with both patients and hospitals," Paul Starr still predicts a backward move of doctors into institutional services, a forward move by hospitals into ambulatory care, and the creation of hybrid prepayment plans by insurance companies.

It may be that the whole book is summed up quite well by a sentence in the final paragraph: "Images of the future are usually only caricatures of the present." If you want to face reality, read this book!

John S. Madara, M.D.

INFORMATION FOR AUTHORS

The Journal, the official organ of the Medical Society of New Jersey, is published monthly under the direction of the Committee on Publication. The goals of *The Journal* are educational and informational. All material published in *The Journal* is copyrighted by the Medical Society of New Jersey.

CONTENT

The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports based on unusual clinical experiences; review articles; clinical notes, succinct items on some aspect or new observation or technique of a case experience; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update, and an opinion column. Editorials are prepared by the Editor and by guest contributors on timely and relevant subjects; editorials are the responsibility of the author. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the Editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of contribution should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made in New Jersey.

ASSIGNMENT OF COPYRIGHT

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978), a transmittal letter or a separate statement accompanying material offered to *The Journal* of the Medical Society of New Jersey must contain the following language and must be signed by all authors:

"In consideration of *The Journal* of the Medical Society of New Jersey taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *The Journal,* MSNJ."

SPECIFICATIONS

Submit two **manuscripts** that must be typewritten and double-spaced on 8-1/2" by 11" paper. This material is for the exclusive use of *The Journal* and will not be published elsewhere except in abstract form or with the consent of the Committee on Publication. Statistical methods used in articles should be identified. Acknowledgments will be made only for specific preparation of an essential part of the manuscript.

Authors are asked to seek clarity, accuracy, and originality; attention to details of grammar, spelling, and typing are important.

The **title page** should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

The author should submit a 50-word **abstract** to be used at the beginning of the article.

Tables must be typewritten and double-spaced on separate 8-1/2" by 11" sheets, with a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source; written permission for republication from the original publisher must be submitted. The cost of color photographs must be borne by the author.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

The **summary** of the article should not exceed 250 words; it should contain only essential facts.

References should not exceed 35 citations except in review articles, and should be cited consecutively in the text by numbers in parentheses at the end of the sentence. The reference list should be typewritten and double-spaced on separate 8-1/2" by 11" sheets in the numerical order in which they are first cited in the text. The style of reference is that of *Index Medicus:*

1. Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis.* New York, NY, McGraw-Hill, 1969, Pp. 42-48.

PUBLICATION POLICY

Receipt of each manuscript will be acknowledged and a copy delivered to the Editor who refers the paper to one or more members of the Editorial Board. The final decision is reserved for the Editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. Galley proofs will be submitted to the author for correction of typographical errors.

REPRINT ORDERS

Reprints may be ordered after the author is notified that the article has been selected for a specific issue of JMSNJ. A check for the cost of reprints including remake charge if order is received after due date must accompany the order.

COMMUNICATIONS

All communications should be sent to the Editor, *The Journal,* MSNJ, 2 Princess Road, Lawrenceville, NJ 08648.



SECOND OPINION

Leasing's not for you?

Compare these figures (based on a $20,000 vehicle):

DUE 1ST DAY	PURCHASE	LEASE*
6% sales tax	$1200	$25/mo.
down payment	4000	none
monthly payment	554	410
total due:	**$5754**	**$435**

So by leasing, you've got $5319 savings on your initial outlay, plus $119 a month, to invest any way you'd like! And insurance is available to qualified N.J. motorists for as little as $480 a year. Call for similar savings on ANY make or model, foreign or domestic. *36-mo/closed-end

value lease inc

Evenings and weekends, call (201) 530-4088

91 Monmouth St., Red Bank, N.J. 07701 (201) 530-1282

FOR SALE—BEST OFFER

ROYAL WORD PROCESSING SYSTEM—"Onmiwriter with text pac, 24 line display, screen, 2 MF disc drives. Moveable keyboard and daisy wheel printer; compatible data-base management.

A.B. DICK, MAGNA II ELECTRONIC TYPEWRITER, compatible with IBM mag card machine, 32 character display, full page memory. Prints 45 characters per/second, daisy wheel printer. Flexible—display allows for adding, deleting, and rearranging without printing on paper. Electronic tab grid, margin and pitch.

Contact: Mr. Robert Cherecwich, Metropolitan Peer Review Organization, 155 Morris Avenue, Springfield, NJ 07081—201-379-6300



EXECUTIVE COLONIAL

Handsome. 12 rooms—7 bedrooms, 3½ baths, 28′ living room, 15½′ dining room, family room PLUS 3 room DOCTOR'S SUITE, nurse's station, lab; parking 13 cars. Westfield. $298,500. REALTY WORLD—Joy Brown, Inc., 112 Elm St., Westfield, N.J. (201) 233-5555.

WE WANT YOUR PRACTICE!

FOR IMMEDIATE SALE

PROFESSIONAL OFFICE CONDO

180 DEAN PLAZA
PRESTIGIOUS ENGLEWOOD, N.J.

Weigh These Advantages

- AT ENGLEWOOD HOSPITAL
- 17,400 SQ. FT. ON 3 FLOORS
- SUPERIOR CONSTRUCTION AND DESIGN
- OWN YOUR OWN SUITE, FULL FLOOR, OR ENTIRE BUILDING
- SUITES AVAILABLE FROM 1,450 SQ. FEET
- BEAUTIFULLY LANDSCAPED 3-STORY ATRIUM
- 90 CAR PARKING
- MUNICIPAL LOT NEXT DOOR
- N.Y. & N.J. BUSES AT DOOR
- A GREAT VALUE AT $137.95 PER SQ. FT.
- DESIGNED AND FINISHED TO SUIT
- LEASE TERMS CAN BE ARRANGED

Call Exclusive Broker

CHARLES KLATSKIN CO.
(201) 288-5700

ROSELAND MEDICAL CENTER

556 Eagle Rock Avenue
Roseland, New Jersey 07068
(At Corner of Eagle Rock Avenue and Eisenhower Parkway, One Block in from Route 208)

PURCHASE OR LEASE

Suites Available from 1000 Square Feet
Finished To Suit

First Floor Presently Occupied By:

ROSELAND SURGICAL CENTER

Excellent Parking Available

FOR MORE INFORMATION PLEASE CONTACT:

or

Nadine L. Smith
Eric Bram & Company
111 Madison Avenue
Morristown, NJ
(201) 285-0110

Michael Shalit
Eric Bram & Company
77 Milltown Road
East Brunswick, NJ
(201) 238-3500

CLASSIFIED ADVERTISEMENTS

ANESTHESIOLOGIST—Seeks position. Board certified, experienced anesthesiologist seeks position in central or south Jersey. Broad clinical experience in all phases of anesthesiology. Small hospital preferred. Resume and details on request. Reply to Mainland Anesthesia, P.A., 52 East New York Avenue, Somers Point, NJ 08244. Call (609) 927-7782.

GENERAL PRACTITIONER—Desires industrial, pharmaceutical or similar position. Semi-retired, age 55. (201) 545-4339.

GENERAL SURGEON—Board certified, wishes to join another surgeon or a group in the area of Monmouth County or adjoining counties. If interested please contact Dr. Hasan (201) 972-1584.

INTERNIST—Available immediately, fellowship in cardiology. Looking for association to join a group or hospital based situation in Southern New Jersey, especially Burlington and Camden counties. Write Box No. 41, JMSNJ.

OB/GYN—Available, UMDNJ Rutgers trained, graduate with broad clinical experience in infertility, colposcopy, maternal-fetal medicine and ambulatory services, seeks private practice in Central-North New Jersey. Write Box No. 59, JMSNJ.

OB/GYN—Available, UMDNJ trained, UMDNJ graduate with broad clinical experience seeks to join private practice in Central-North New Jersey or Manhattan. Speaks fluent Spanish. Write Box No. 60, JMSNJ.

OPHTHALMOLOGIST—Desires partnership or group. Board eligible July 1984, board certified ped (1982), age 29. Available July 1984. Write Box No. 58, JMSNJ.

ORTHOPEDIC SURGEON—Desires association with group or solo. Board eligible, Albert Einstein 1978, Mt. Sinai (NY) orthopedic residency 1983. Presently in Arthritis Total Joint Replacement Fellowship at University of Colorado. Available July 1984. Berton Taffet, M.D., 1177 Race St., Denver, CO 80206. Phone (303) 320-6355.

PHYSICIAN—Semi-retired, 57 years old, seeking part time or full time position. Preferable, industrial clinic. Telephone (201) 224-5252.

NEEDED—Cardiologist/General internist. Multi-specialty group, Southern New Jersey, seeking a board certified/eligible cardiologist and general internist. Send C.V. to Box No. 54, JMSNJ.

NEEDED—Internist. Board certified or eligible to join 10-man multi-specialty group in suburban Morris County, NJ. Immediate opening available for permanent position. Send C.V. to Box No. 44, JMSNJ.

NEEDED—Internist/Cardiologist. To join 2 clinical cardiologists. Busy practice in South Jersey community. 35 minutes from Philadelphia and Atlantic City. Respond with C.V. to Box No. 45, JMSNJ.

NEEDED—Internist, Board certified/eligible. Must have had training in cardiology, gastroenterology and endoscopy for association position in busy general practice Northern New Jersey suburban setting. Submit resume to Box No. 56, JMSNJ.

NEEDED—Internist. Board certified/eligible to join former New Jersey internist now in solo practice in Blue Ridge/Smokey Mountain cosmopolitan community. Salary first year plus all fringes, then partnership progression. Send CV to Box No. 57, JMSNJ.

NEEDED—OB/GYN. To join solo practice in South Jersey shore area. Growing area, one hour from Philadelphia. Write Box No. 42, JMSNJ.

NEEDED—Associate. Pediatrician board certified, seeks associate (board certified/eligible) to join well established practice. Excellent opportunity. Northern New Jersey near New York City. Write Box No. 40, JMSNJ.

NEEDED—Primary Care Physicians. Private fee-for-servive practice in new, fully equipped suburban offices. All personnel supplies, and management services provided. This is an excellent opportunity for physicians with a good "bedside" manner interested in developing a lucrative practice and still desiring time for the pursuit of happiness. Reply to Neighborhood Doctor Corporation, 901 Long Beach Blvd., Ship Bottom, NJ 08008.

NEEDED—Radiologist. Part time, 2 mornings per week. Ocean County. Prefer competent retired person. Write Box No. 62, JMSNJ.

WANTED—Ghost writer for Medical Articles for publication. Write P.O. Box 61, Livingston, NJ 07039.

PRACTICE/ALLERGIST—Certified or board eligible for purchase of very desirable Practice, child and adult. Central NJ. Write Box No. 47, JMSNJ.

FOR SALE—Practice, established, lucrative, excellent location. Office fully equipped, ready to take over. Exceptional opportunity for young physician. Two family house, six rooms and two baths. Available if required. Jersey City. (201) 433-0743.

FOR SALE—Home/Office. Large beautiful home with doctor's office in Summit. Seven bedrooms, four full bathrooms, three powder rooms, four fireplaces. Office at ground level, completely furnished with large waiting room, receptionist and bookkeeping area, five large examining rooms. Separate entrance and exit. Twenty car parking area. House and office have fire, smoke and burglar alarms. Separate three-car carriage house with four-room apartment (two bedrooms). Swimming pool 22' x 46', close to two acres beautifully landscaped. Five minutes from Overlook Hospital. Please write to Box No. 28, JMSNJ.

FOR SALE—Family Practice or rent office and equipment near a 550 bed teaching hospital in Monmouth County. Call after 6 P.M. (201) 681-2566.

FOR SALE or RENT—Fully equipped and furnished medical office building including small medical practice. ECG, x-ray machines, Therapeutic Ultrasound, Pulmonor. Good location, Kearny, NJ. Call after 8 P.M. (201) 746-1709.

MEDICAL OFFICE—Half interest in medical office with rental income. Three private rooms, internist equipment and furnishings. Shared use of common areas. Central Middlesex County location. Offered at $60,000, financing available. Also available for rent at $700. monthly including all utilities, equipment and furnishings. Write Box No. 61, JMSNJ.

OFFICE SPACE FOR SALE—Roselle. Modern 2,400 square feet. 6 treatment rooms and 4 consultation rooms. On-site parking. Warinanco Medical Building. Phone (201) 687-0102.

OFFICE FOR RENT—Bergen County, Ridgefield, NJ. 700 square feet. Call (201) 833-0117.

OFFICE SPACE—Edison. 1214 square feet, 8 rooms, bathroom, carpeted, near all highways and hospitals. On-site parking, available immediately. Dr. Bronstein (201) 738-8000.

OFFICE SPACE For Rent—1300 square feet. New building, 712 Amboy Avenue, Edison. Ample parking, no steps. Near Perth Amboy and JFK hospitals. Call (201) 442-4444.

OFFICE SPACE—Moorestown, NJ. Victoria Medical Arts Building. Renting custom medical offices in new building. Ideal for radiologist, orthopedist, urologist, general surgeon, industrial physician. Excellent location and parking. Call (609) 235-2651.

MEDICAL OFFICE For Rent—Great location in resort center Vernon. Manager on site, easy terms. (201) 764-3330 days, (201) 382-6284 nights and weekends.

OFFICE FOR SHARE—Berkeley Heights. 800 square feet in professional building. Interested parties write to P.O. Box 1293, Summit, NJ 07901.

OFFICE FOR SHARE—Highland Park. 900 square feet office space. Fully equipped, near hospital. Minimal rent, $250. per month including utility and equipment. For details call (201) 545-2045.

SHARE OFFICE—Ridgewood, near Valley Hospital. Prime medical space, new building. Large parking lot, easily accessible, on main road. Call (201) 652-6060.

Want to expand your practice?
we are
SPECIALISTS
in
PUBLIC RELATIONS
FOR THE MEDICAL PROFESSION
for a confidential interview call—
(201) 531-7080
phyllis kessel associates
780 West Park Avenue, Oakhurst, N.J. 07755

PROGESTERONE SUPPOSITORIES
25 mg., 50 mg., 100 mg., 200 mg., & 400 mg.
Boric Acid Suppositories 600 mg.
in Polyethylene Glycol Base for
Vaginal Use, are now being
compounded at the following Pharmacy
Hidden Lakes Pharmacy
2039 Rt. #27, Somerset, N.J. 08873 201-821-8500
Howard L. Rubenstein, R.Ph.
Specific dosage and ingredient requirements can be tailored to your patients needs. We specialize in compounding prescriptions.
Delivery available to your patients home. Call for details.

TAXES AND ACCOUNTING
AFFECT YOUR PROFITABILITY!
GEIN, CONNOLLY & SWITAJ
Certified Public Accountants
Central New Jersey CPA Firm Providing Tax, Accounting and Management Advisory Services to the Medical Profession.
721 North Beers Street
Holmdel, New Jersey 07733
(201) 739-2020

FOR SALE: two ten percent interests in a New Jersey Subchapter "S" equipment leasing corporation. Prefer New Jersey Physician with former or current military affiliation. Write to Col John T. Evans or Maj Edward K. Ernstrom at First National Equipment Corporation, Ten Woodhill Road, Towaco, New Jersey 07082. Tel 4:30 pm to 9:00 pm 201-263-5054.

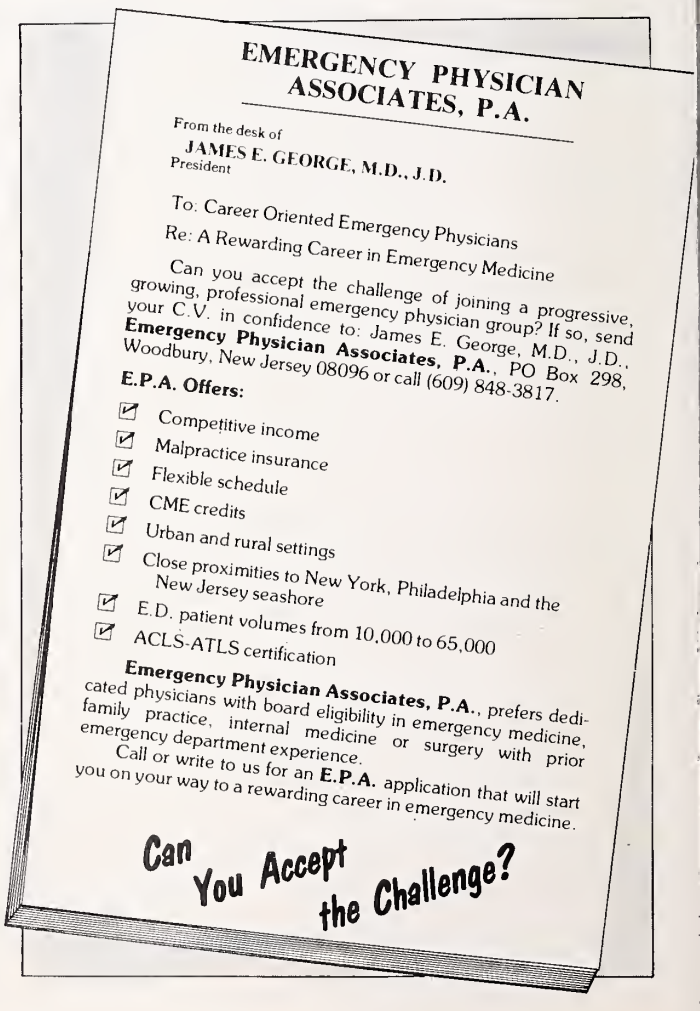
A SPECIAL PRACTICE FOR SPECIALISTS

If you're a surgeon or OB/GYN or other medical specialist, the Air Force may have a special practice for you.

What makes it special? You'll enjoy an excellent pay and benefits package. Your regular working hours will allow you to spend more time with your family. You'll receive 30 days of vacation with pay each year. And you will work with modern equipment and some of the most highly trained professionals in the world, serving your country and your patients. Now that's special!

FIND OUT JUST HOW SPECIAL YOUR PRACTICE CAN BE. Contact:
TSGT ED PORTER—(201) 790-8116/8117
CALL COLLECT

AIR FORCE
A great way of life.



THE JOURNAL OF THE MEDICAL SOCIETY OF

NEW JERSEY

FEBRUARY 1984



The Library
Acquisitions Division
Univ. of Calif., San Francisco
94143

Send this coupon for no-obligation information of the savings under the Medical Society of New Jersey Endorsed Insurance Plans

Check this list against your coverages . . . .

- ☐ $5000 Monthly Guaranteed Convertible Accident and Health
- ☐ $10,000 Monthly Practice Overhead Expense
- ☐ $1,250,000 Term Life Insurance
- ☐ $500 Deductible COMPREHENSIVE MILLION-DOLLAR MAJOR MEDICAL PLAN—No other coverage needed—Issuable to Age 69
- ☐ $15,000 Deductible MILLION-DOLLAR UMBRELLA MAJOR MEDICAL PLAN for holders of Blue Cross and other Major Medical Plans—Issuable to Age 69
- ☐ $100-a-day Hospital Income Policy
- ☐ $200,000 High Limit Accident Plan
- ☐ Keogh and Corporate Plan NOW! $15,000 KEOGH

E. & W. Blanksteen Agency, Inc.

E. & W. Blanksteen
75 Montgomery St.,
Jersey City, N.J. 07302
(201) 333-4340
or (800) 742-2849

Name: _____

Address: _____

_____

Tel. No. _____

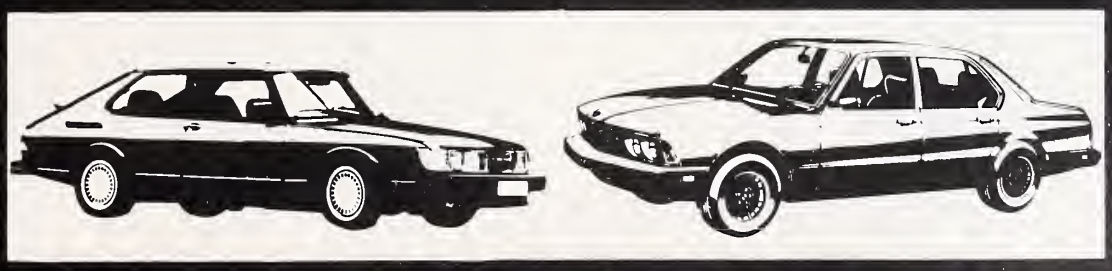
Best Time To Call _____

JMK

BMW

SAAB

Our reputation has been built on our SERVICE



JMK AUTO SALES

391 Rt. 22 (East) Springfield, New Jersey

379-7744

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

Officers and Trustees

PRESIDENT
Alexander D. Kovacs, M.D. (Union) ..... Scotch Plains
PRESIDENT-ELECT
Frank Y. Watson, M.D. (Essex) ..... Glen Ridge
FIRST VICE PRESIDENT
Ralph J. Fioretti, M.D. (Bergen) ..... Rochelle Park
SECOND VICE PRESIDENT
Edward A. Schauer, M.D. (Monmouth) ..... Farmingdale
IMMEDIATE PAST PRESIDENT
Howard D. Slobodien, M.D. (Middlesex) ..... Metuchen
SECRETARY
Arthur Bernstein, M.D. (Essex) ..... South Orange
TREASURER
Paul J. Hirsch, M.D. (Somerset) ..... Bridgewater

Trustees

Douglas M. Costabile, M.D., *Chairman* (1984) (Union) .. Murray Hill
Frank Campo, M.D. (1984) (Mercer) ..... Trenton
Harry M. Carnes, M.D. (1985) (Camden) ..... Audubon
Joel S. Cherashore, M.D. (1986) (Essex) ..... Nutley
John J. Crosby, Jr., M.D. (1984) ..... Jersey City
Palma E. Formica, M.D. (1984) (Middlesex) ..... New Brunswick
Harry W. Fullerton, Jr., M.D. (1985) (Salem) ..... Carney's Point
Frank Gingerelli, M.D. (1986) (Bergen) ..... Hackensack
William Greifinger, M.D. (1984) (Essex) ..... Belleville
John P. Kengeter, M.D. (1984) (Ocean) ..... Toms River
Edwin W. Messey, M.D. (1985) (Burlington) ..... Willingboro
Myles C. Morrison, Jr., M.D. (1985) (Morris) ..... Morristown
John J. Pastore, M.D. (1986) (Cumberland) ..... Vineland
Michael R. Ramundo, M.D. (1984) (Passaic) ..... Clifton

Councilors

FIRST DISTRICT
(Essex, Morris, Union, and Warren Counties)
Edward M. Coe, M.D. (1984) ..... Cranford
SECOND DISTRICT
(Bergen, Hudson, Passaic, and Sussex Counties)
Robert A. Weinstein, M.D. (1986) ..... Newton
THIRD DISTRICT
(Hunterdon, Mercer, Middlesex, and Somerset Counties)
Albert F. Moriconi, M.D. (1985) ..... Trenton
FOURTH DISTRICT
(Burlington, Camden, Monmouth, and Ocean Counties)
Frederick W. Durham, M.D. (1984) ..... Haddonfield
FIFTH DISTRICT
(Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties)
Paul H. Steel, M.D. (1986) ..... Atlantic City

AMA Delegates

William J. D'Elia, M.D., *Chairman* (1985) ..... Spring Lake
Alfred A. Alessi, M.D. (1984) ..... Hackensack
Frederick W. Durham, M.D. (1984) ..... Haddonfield
Palma E. Formica, M.D. (1984) ..... New Brunswick
Karl T. Franzoni, M.D. (1984) ..... Trenton
John S. Madara, M.D. (1984) ..... Salem
Henry J. Mineur, M.D. (1984) ..... Cranford
Myles C. Morrison, Jr., M.D. (1985) ..... Morristown
Howard D. Slobodien, M.D. (1985) ..... Metuchen

AMA Trustee

James S. Todd, M.D. (Ridgewood) ..... Bergen

February 1984

Publication Committee

Paul J. Hirsch, M.D., *Chairman*
Dirck L. Brendlinger, M.D.
Frederick B. Cohen, M.D.
A. Olusegun Fayemi, M.D.
Robert M. MacMillan, M.D.
Leon G. Smith, M.D.
La Verne Fioretti

Editor

Arthur Krosnick, M.D.

Managing Editor

Geraldine R. Hutner

Assistant Managing Editor

Dorothy J. Griffith

Advertising Manager

E. Elizabeth Cookson

Executive Director

Vincent A. Maressa

Executive Director Emeritus

Richard I. Nevin

Editorial Board

Jerome Abrams, M.D. (Obstet/Gynecol)
Harold Arlen, M.D. (Otolaryngol)
Alfonse Cinotti, M.D. (Ophthalmol)
Stuart D. Cook, M.D. (Neurol)
Robert Dodelson, M.D. (Nephrol)
Wm. A. Dwyer, Jr., M.D. (Surg)
Norman H. Ertel, M.D. (Int Med/Endocrinol)
Arthur Goldfarb, M.D. (Allerg/Clin Immunol)
Christine E. Haycock, M.D. (Sports Med)
Monroe S. Karetzky, M.D. (Pulmon Med)
Avrum L. Katcher, M.D. (Pediatr)
Joel D. Levinson, M.D. (Gastroenterol)
Henry R. Liss, M.D. (Neurosurg)
Geobel A. Marin, M.D. (Int Med/Gastroenterol)
Robby Meijer, M.D. (Plas Surg)
Christopher A. Papa, M.D. (Dermatol)
Victor Parsonnet, M.D. (Vasc Surg)
Norman Riegel, M.D. (Book Review)
Edwin L. Rothfield, M.D. (Cardiol)
Benjamin F, Rush, Jr., M.D. (Surg)
Morris H. Saffron, M.D. (Med His)
Mark M. Singer, M.D. (Int Med/Endocrinol)
Sheldon D. Solomon, M.D. (Rheum)
Lloyd N. Spindell, M.D. (Radiol)
A. Arthur Sugerman, M.D. (Psychiat)
Edwin S. Wilson, M.D. (Radiol)
Louis S. Zeiger, M.D. (Nucl Med)
Robert B. Zufall, M.D. (Urol)

The Journal of the Medical Society of New Jersey (ISSN-0025-7524) is published monthly (since 1904) except semimonthly in July (13 issues), under direction of the Committee on Publication, by the Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648. Printed in East Stroudsburg, PA, by the Hughes Printing Co. Whole number of issues 959. Member's subscription ($10) is included in Society dues. Rates for nonmembers, $20; outside USA add $7.50 for postage. Single copies, $2. Address communications to *The Journal* MSNJ, 2 Princess Road, Lawrenceville, NJ 08648, (609) 896-1766. Second-class postage paid at Trenton, NJ, and additional entry office.

Copyright 1984 by the Medical Society of New Jersey.

TAX PREPARATION AND PLANNING

Individual, Partnership, Corporate, Business, Estate
Services
Expert Services
Federal, Any State, Foreign Taxes of any type
All Year Service
Audit Representation
Tax Planning and Reduction
In Home or In Office Service

H. Michael Zukowski
(201) 945-8443

Want to expand your practice?
we are
SPECIALISTS
in
PUBLIC RELATIONS
FOR THE MEDICAL PROFESSION
for a confidential interview call—
(201) 531-7080

phyllis kessel associates
780 West Park Avenue, Oakhurst, N.J. 07755

YOUR OFFICE IS OUR BUSINESS.

You're a professional in your field and so are we. We specialize in the design and furnishing of offices — interiors that suit the needs and desires of our clients. Your choices are limited only by your imagination. Using all major lines of contract furniture, custom cabinetry, open office systems and accessories, as well as floor and wall coverings, and window treatments, we can create an office ideally suited to your special needs. Your office is our only business

FARKAS
BUSINESS INTERIORS INC.
SIXTEEN PINE STREET
MORRISTOWN, NEW JERSEY 07960
(201) 267-1065
MONDAY-FRIDAY 9:00 A.M.-5:00 P.M. SATURDAY 10:00 A.M.-2:00 P.M.

If your professional liability insurance company ran out of money, you could find yourself very much . . .

. . . alone.

We're 6,900 New Jersey physicians insuring *ourselves* through our own non-profit company. If you haven't joined us, you could be more at risk than you know. You owe it to yourself — and those that depend on you — to call us for more information.

800-257-6288

Do it now. Everything is at stake.

A professional service message from the
Medical Inter-Insurance Exchange of N.J.
Two Princess Road, Lawrenceville, NJ 08648
(609) 896-2404
*"The **Doctors'** Company"*

February 1984

Journal of the Medical Society of New Jersey

America's First Medical Society

CONTENTS

94 **MEMBERSHIP NEWSLETTER**

99 **PROFESSIONAL LIABILITY COMMENTARY**

EDITORIALS

105 Blood Banks and AIDS

105 Sir Frederick G. Banting—The Artist

106 Baby Doe and the Prognosis Committee

107 **HOSPITAL GOVERNING BOARDS**

ARTICLES

110 Postmyocardial Infarction Rupture of the Ventricular Septum
S.K. Agarwal, M.D., J. Haft, M.D., J. Goldstein, M.D., Newark

113 The First Clinical Year of Medical School
H. Kranzler, M.D., K. Vitting, M.D., R.C. Reynolds, M.D., Piscataway

121 Is There an Indigenous Viral Flora in Man?
F.J. Michalski, Ph.D., Newark

125 May a Blood Bank Refuse Donations To Prevent the Spread of AIDS?
L.G. Smith, M.D., R. Brennan, LL.D., B. McDonough, J.D., Newark

CASE REPORTS

131 Hydatid Disease of the Liver
M.A. Kessler, M.D., S. Ketyer, M.D., J.V. Cholankeril, M.D., J. Cenizal, M.D., Eliz.

135 Fine-Needle Aspiration in Metastatic Malignant Melanoma
D. Rothman, M.D., Y. Olaizola, M.D., J. Baker, C.T., Red Bank

MEDICAL HISTORY AND ART

138 The Art of Banting
A. Krosnick, M.D., Lawrenceville

IMPAIRED PHYSICIANS PROGRAM

140 Advocacy
D.I. Canavan, M.D., Lawrenceville

DOCTORS' NOTEBOOK

143 Trustees' Minutes: December 16, 1983

144 President's Column, *Alexander D. Kovacs, M.D.*

144 UMDNJ Notes, *Stanley S. Bergen, Jr., M.D.*

145 MSNJ Auxiliary, *Mrs. Gale Wayman*

145 AMNJ Report, *Paul J. Hirsch, M.D.*

146 Task Force on Fetal Alcohol Syndrome

146 Physicians Seeking Location in New Jersey

149 CME Calendar

153 Letter to the Editor

154 Obituaries

155 Book Reviews

157 Information for Authors



On The Cover: Sir Frederick Banting, Nobel Laureate for the discovery of insulin, was an amateur artist. The original watercolor sketch on our cover provides the perfect reason to discuss the art of Banting. Read the full story on page 138. The watercolor belongs to Mrs. Sylvia Swern of Trenton.

CYCARE COMMITMENT



IT'S MADE US THE LEADER ACROSS NORTH AMERICA... AND NEW JERSEY

n-house data processing is available from many sources. But when you invest in CyCare 100, you'll get omething you can't get anywhere else...our ommitment to you.

It means concentrating our efforts on a single ndustry since 1968. Your industry.

It means giving you the benefit of the millions of dollars we're spending on research & development annually.

And, it means providing ongoing training and prompt service through our regional office near you.

Our commitment has paid off for 621 group practices across the United States and Canada. But the most important place we can put it to work is where you work.

Get the full story about CyCare 100, a system designed for practices with 2 or more physicians. Phone **(609) 667-8894** or write today. You'll learn it now costs no more to go with the leader.

Mail to:
CyCare Suite 308
1030 Kings Highway North
Cherry Hill, NJ 08034

☐ Rush free details to me about CyCare 100. My business card is attached.

☐ Have a representative contact me.

cycare®

North America's leading provider of data processing services, software and systems for medical group practices.

MEMBERSHIP NEWSLETTER

MSNJ

THE MEDICAL SOCIETY OF NEW JERSEY VOLUME

DISCIPLINARY ACTIONS

Two cases concluded by the State Board of Medical Examiners (SBME) in November 1983 demonstrate situations which are a potential threat to physicians and patients alike. These cases are discussed for the guidance of the membership.

Experimental Drugs. A physician administered a drug not approved by the Food and Drug Administration (procaine polyvinylpyrrolidone) to about 15 patients without appropriate review of the substance's efficacy. There was no evidence that patients were injured or that the physician knew the drug had not been approved. The license of the doctor was suspended for one year and stayed. He was assessed a fine of $2,500, enjoined from the further administration of the drug, and assessed costs of $4,160. In addition, $960 is to be repaid to one of the patients. Caution: Please be sure when administering drugs that they are FDA approved for use or that you have an investigational permit.

Life Insurance Physical Examinations. A physician, socially aquainted with another physician and his wife, completed a medical examination form for the couple so that they could apply for life insurance. The physician executed the certification that indicated he had conducted a personal physical examination of the applicants. He collected the examining fee paid by the carrier. The factual presentation at the administrative hearing indicated that the couple had filled in the form. The certifying physician did not conduct an examination, nor did he fill in or dictate the answers on the forms. The State Board ruled that the physician's actions constituted professional misconduct and a demonstrated lack of good moral character. His license was suspended for one year and the suspension stayed. He was assessed a penalty of $5,000 and costs of $115. Caution: When completing life insurance examination forms, please conduct a complete history and physical of the applicant and thoroughly document your findings and conclusions.

RABIES CONTROL

The continued migration of wildlife rabies from th southeastern to northeastern parts of the United State is an indication that New Jersey may be vulnerable t an outbreak of rabies.

It has been suggested by the Department of Healt Biological Services Program that clinics be organize on a county or regional basis. Robert F. Goldsborc D.V.M., M.P.H., Coordinator, Veterinary Publi Health Biological Services Program, will be contactin the president of each county society to outline the pla of control and to seek physician support where needed For further information, call 609-984-1378.

CERTIFICATE OF NEED

At the November meeting of the Statewide Healt Coordinating Council (SHCC), the Department o Health recommended that a diagnostic radiologica service be deemed a health care facility and thereb subject to a certificate of need.

The radiological service is organized as a pro fessional corporation and names five individuals a members of the Board of Directors. All five Boarc members are physicians, but none are radiologists. A such, these physicians are not practitioners at the fa cility; diagnostic radiological services are provided by radiologists who are members of a radiology group. In addition, the corporation employs a full-time office manager, a full-time secretary, two full-time x-ray technicians, and a part-time darkroom technician.

Utilizing the Marsh decision as a basis for the recommendation, the Health Department stated, "Only a 'physician in his private practice' is exempted from the certificate of need requirements, but the Health Care Facilities Planning Act does not define this term. Nevertheless, the term and the exemption were subjects of the landmark case, Marsh *v* Finley. In that case, Dr. Albert Marsh, a radiologist and solo practitioner, sought to install a Computerized Axial Tomo-

aphy (CAT) scanner in his private practice. It was ound that Marsh was undeniably a private practioner who desired to augment his private practice by stalling in his office a piece of equipment directly elated to his radiology practice. The Court noted that Marsh's practice 'does not involve merely the rovision of facilities for medical diagnosis and treatent as in a hospital or other institutional facility, but he actual diagnosis and treatment of patients seeking is aid.' The Court also stated: 'Plaintiff's practice and he tools he uses are inseparable. The scanner apparently will be only one of many diagnostic tools which are incidental to this specialty of radiology.

"A comparison of the diagnostic radiological service n question to Dr. Marsh's practice clearly shows that here are significant differences. Structurally, the hareholders of the diagnostic radiological service unction as investors and corporate owners, not as hysicians. Unlike Dr. Marsh who is engaged in 'the ctual diagnosis and treatment of patients' the physician-shareholders of the diagnostic radiological service are not radiologists. In addition, there is no connection between the equipment owned by the liagnostic radiological service and the individual practices of its physician-shareholders. Only the practice of adiology could logically be said to be 'inseparable' rom the equipment housed in the facility."

Given these findings, the Department of Health recommended that "this diagnostic radiological service be deemed a health-care facility subject to the certificate of need requirements of the Health Care Facilities Planning Act. Such a determination is considered essential for effectuating the cost-containment purposes of nuclear magnetic resonance imaging.

WHAT DOCTOR/PATIENT RELATIONSHIP?

Physicians no longer are physicians; they now are referred to as providers. Recently, we were informed that in Arizona, primary care physicians will be referred to as "gate keepers." How much lower can we go? Patients no longer are patients because now they are consumers. And what happens between a physician and a patient now is referred to as an encounter. The context is all wrong and the result is a further weakening of the doctor/patient relationship. It is as if we are dealing with potatoes and canned corn—according to Ernest E. Simard, M.D., Past President, College of American Pathologists.

JCAH PUBLISHES NEW GUIDE

The Joint Commission on Accreditation of Hospitals (JCAH) has announced publication of the *Hospice Standards Manual* and the *Hospice Self-Assessment and Survey Guide.* The *Manual* contains standards to be used in the assessment of hospice programs that apply for a JCAH accreditation survey through the Accreditation Program for Hospice Care. The *Manual* also includes a statement of principles reflecting the essence of hospice care, a "Using the Manual" section that explains how the *Manual* may best be suited to the particular needs of each hospice program, and a "General Administrative Policies and Procedures" section that includes information on the survey process. The *Guide,* a companion publication to the *Manual,* is designed as an educational and self-evaluation tool that further will assist hospice program staff in preparing for a JCAH survey.

To order books, please send $25 for each publication to: Cashier: JCAH, 875 North Michigan Avenue, Chicago, IL 60611. For further information regarding any JCAH publication, telephone the Department of Publications at (312) 642-6061.

LASER SURGERY

The nation's 11,000 ophthalmologists are turning from scalpels to lasers as their preferred surgical instrument. Conditions as diverse as glaucoma and retinal disease are alleviated without benefit of a knife, and lasers are effective in radial keratomy (incisions in the cornea), lens operations, and other procedures.

The laser is a deft tool because it permits "noninvasive" surgery—noinvasion of the body, and no cutting. A coherent light beam is focused inside the eye at the point where the tip of a scalpel might otherwise be. But only the laser "tip" has an effect; the light waves pass harmlessly through intervening tissue.

In treating glaucoma, for example, the laser beam makes tiny marks on the trabecular network. In glaucoma, this meshlike network of connective tissues gets clogged, impeding the flow of the aqueous fluid. This fluid is to the eye as blood is to the body; it carries nutrients throughout the eye tissues, and carries waste products away. When the flow is obstructed, vision is impaired.

The laser beam "scratches" portions of the trabecular network by creating minute burns. These burns contract the network in spots, as scabs draw surrounding skin together. Portions of the network thus open up, allowing the aqueous fluid to flow freely again.

Ophthalmologists also use lasers in a "photocoagular" process that stops bleeding in the eye's interior. "Welding" of lenses and other eye parts is also performed employing a laser.

Comment: Through ophthalmic laser instrumentation, the complications of surgery by scalpel are avoided. An operation requiring three days in the hospital may be performed by laser on an outpatient basis in half an hour.

PHYSICIANS' SERVICES

Pursuant to Executive Order No. 66 (1978), the Division of Medical Assistance and Health Services is proposing to readopt Subchapter 1 of the *Manual for Physicians' Services.* The proposal appeared in the De-

cember 19, 1983, issue of the *New Jersey Register.*

There are some changes on readoption, which are designed to clarify existing Medicaid policy. Changes include an update to the childhood immunization policy to conform with the *Procedure Code Manual,* deletion of reference to A.I.D. (Approval by Individual Diagnosis), and revisions to the sections dealing with pharmaceuticals to insure conformity with the *Pharmacy Manual.*

RETIRED LIVES RESERVE

The following article was written by William P. Squire, Jr., President, Professional Corporations Ltd., Washington, D.C.

The Medical Society of New Jersey recently has endorsed a new benefit plan for members called Retired Lives Reserve. This is the only tax-advantaged method available to continue group term life insurance after a physician retires. Group term life insurance almost always is terminated either at or shortly after retirement. If a physician dies after retirement (usually the case), his family is left without the group term life benefit. Retired Lives Reserve is an annual funding program accomplished during a physician's working lifetime to provide enough money at retirement to continue paying premiums on the group term policy until he dies. Retired Lives Reserve converts a terminable benefit into one that is guaranteed and permanent.

Retired Lives Reserve has four tax advantages: (1) The deposits placed in the reserve fund are tax deductible to the corporation. (2) The interest earnings on the reserve fund are not taxed as income to the physician. (3) The proceeds at death pass income tax free to the beneficiary. (4) If a spouse or marital trust is named the beneficiary, the proceeds avoid federal estate taxes.

This is the only property afforded all four tax advantages by the Internal Revenue Code. These powerful tax advantages make the Retired Lives Reserve Plan particularly attractive for physicians.

Because of the changes under the new "Tax Equity and Fiscal Responsibility Act" of 1982 (TEFRA), any benefit over $100,000 from qualified pension or profit-sharing plans now are subject to federal estate taxes, and current tax rates could claim about half of the retirement plan(s) proceeds. Thus, if conventional life insurance is in a qualified retirement plan, its proceeds will be subject to federal estate tax erosion. This would not be the case with Retired Lives Reserve, where effective planning will avoid the federal estate tax on death benefits.

A qualified pension or profit-sharing plan tied together with a Retired Lives Reserve Plan is the answer because it will provide permanent life insurance benefits and eliminate the problem caused by conventional life insurance. Retired Lives Reserve gives the physician the economy of term insurance with the permanency of whole life insurance. The economy is magnified with tax deductible premiums and tax free growth. At retirement, the life insurance is paid in full and is perpetuated—not cancelled or transferred to the physician causing a monetary burden. Unlike qualified retirement plan benefits, the death benefit of a Retired Lives Reserve Plan is received by the physician's beneficiary free of income tax.

TEFRA also has imposed serious limitations on the annual contributions and ultimate payout benefits of qualified retirement plans. Restrictions also have been placed on "top heavy" plans. These new statutory limitations will have a restrictive effect on many plans which have favored the highly compensated physician. As a result, there should be an abundance of funds available, which in the past went to contributions to qualified plans, and presumably now will have no place to go.

But these released funds will have a place to go; namely, into a Retired Lives Reserve Plan. TEFRA is an evil wind, but even an evil wind often blows some good.

For additional information on the new Retired Lives Reserve Plan sponsored by the Medical Society of New Jersey contact, Joseph C. Lucci, Director of Medical and Insurance Affairs, MSNJ, 2 Princess Road, Lawrenceville, NJ 08648.

SPORTS MEDICINE SYMPOSIUM

The Second Annual Garden State Symposium, sponsored by the Mid-Atlantic Chapter of the American College of Sports Medicine, the Medical Society of New Jersey's Committee on Medical Aspects of Sports, and the Institute for Medicine in Sports of Hamilton Hospital, will take place on April 5, 6, and 7, at the Ramada Inn, East Brunswick. For more information contact: The Institute for Medicine in Sports of Hamilton Hospital, P.O. Box 2621, Hamilton, NJ 08690, or call Mrs. Ann Clutter (609) 586-7900, x6402.

FINI

Some people see things as they are, and ask why?
Some people see things that never were, and ask why not.
Robert Frost

Motrin®
ibuprofen, Upjohn
600 mg Tablets



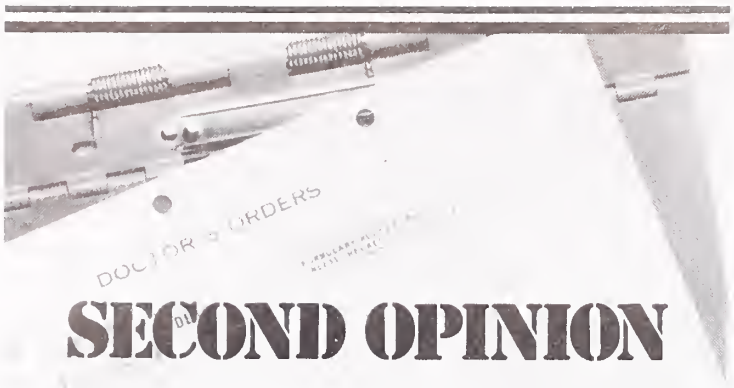
More convenient for your patients.

Upjohn

The Upjohn Company

The Upjohn Company • Kalamazoo, Michigan 49001 USA

J-4044 January 1984



SECOND OPINION

Leasing's not for you?

Compare these figures (based on a $20,000 vehicle):

DUE 1ST DAY	PURCHASE	LEASE*
6% sales tax	$1200	$25/mo.
down payment	4000	none
monthly payment	554	410
total due:	**$5754**	**$435**

So by leasing, you've got $5319 savings on your initial outlay, plus $119 a month, to invest any way you'd like! And insurance is available to qualified N.J. motorists for as little as $480 a year. Call for similar savings on ANY make or model, foreign or domestic. *36-mo/closed-end

value lease inc

Evenings and weekends, call (201) 530-4088

91 Monmouth St., Red Bank, N.J. 07701 (201) 530-1282

TAXES AND ACCOUNTING AFFECT YOUR PROFITABILITY!

GEIN, CONNOLLY & SWITAJ

Certified Public Accountants

Central New Jersey CPA Firm Providing Tax, Accounting and Management Advisory Services to the Medical Profession.

721 North Beers Street
Holmdel, New Jersey 07733
(201) 739-2020

PROGESTERONE SUPPOSITORIES
25 mg., 50 mg., 100 mg., 200 mg., & 400 mg
Boric Acid Suppositories 600 mg.

in Polyethylene Glycol Base for Vaginal Use, are now being compounded at the following Pharmacy

Hidden Lakes Pharmacy

2039 Rt. #27, Somerset, N.J. 08873 201-821-8500
Howard L. Rubenstein, R.Ph.

Specific dosage and ingredient requirements can be tailored to your patients needs. We specialize in compounding prescriptions.

Delivery available to your patients home. Call for details.

Doctors: Write your own prescription to cure insurance pains . . .

℞ Prescription

Name MSNJ Member

MSNJ Group
Blue Cross/Blue Shield
Major Medical and Dental Insurance

that provides:

- **Flexible plans**
- **Comprehensive benefits**
- **Low, competitive rates**
- **Centralized Administration**

Designed and Administered by
DONALD F. SMITH & ASSOCIATES

℞ Prescription

Name _____

Address _____

Phone _____

Please send more information on the MSNJ

- ☐ Blue Cross/Blue Shield Program
- ☐ Major Medical Program
- ☐ Group Dental Program

Return to:
Donald F. Smith & Associates
One Airport Place, Route 206 North
P.O. Box 2197,
Princeton, New Jersey 08540
(609) 924-8700, (201) 622-6046

Negligence Suits, Baby Doe Hotline, and Emergicenters

The partners of a deceased physician were liable for $375,000 in damages for his negligent treatment of a patient, the highest court of Massachusetts ruled in Van Dyke v. Bixby, 448 N.E. 2d 353 (Mass. Sup. Jud. Ct., April 8, 1983).

The physician practiced medicine with several other physicians in 1959, when he operated on the patient for cancer of the rectum. In 1962, the physicians formed a partnership. In July 1969, the patient returned to the physician complaining of severe pain. He performed two operations—one for twisted bowel and one for adhesions. A single Penrose drain was inserted during one of the operations.

Two months later the patient came back to the physician with an abscess in his perineum, which the physician drained. The drainage persisted and he tried to cauterize the abscess with a silver nitrate stick. He told his patient that those problems often take a long time to go away. On January , 1970, the partnership ended and a corporation succeeded it. The patient saw the physician several times during the first half of 1970.

The abscess continued to drain during the next several years, causing a substantial unpleasant odor and considerable discomfort. In 1978, another physician performed a sinogram. The perineal sinus was explored, part of the patient's coccyx was removed, and a Penrose drain was found above the sinus tract and in front of the coccyx.

The treating physician died in 1975, and the patient filed suit against the nine physicians who were his partners. A trial court returned a verdict of $375,000 in favor of the patient and the physicians appealed.

On appeal, the court said that the evidence was sufficient to show that a partnership existed. There was testimony that the patient received joint bills, that a certificate filed with the city clerk was signed by all ten physicians, that they insured their liability as partners, and that certain of the physicians stated that they were partners.

The evidence was sufficient to find the physician negligent for failing to remove the Penrose drain and delaying in taking action to correct the cause of the drainage. *(The Citation,* November 1, 1983, Vol. 48, No. 2)

BABY DOE SQUADS TRACK THREE VALID COMPLAINTS

Responding to 33 complaints on the "Baby Doe Hotline," representatives of the Department of Health and Human Services sent teams of physicians and civil rights investigators to check out 11 complaints. Complaints were unsubstantiated in eight cases, but in three others, they helped save the lives of handicapped infants, *Time* magazine reported September 26, 1983.

Interestingly, the problem in the three cases is one that may sometimes be at the root of malpractice suits. "Doctors seem to be unaware of new techniques for treating birth defects," the magazine reported. The American Academy of Pediatrics, which with other professional organizations is fighting against the controversial "Baby Doe" regulations that interpose the government between physicians, hospitals, and the parents of handicapped infants, agrees, arguing that the best way to help afflicted babies is by "better educating doctors about medical advances" and by creating infant bioethical review committees in hospitals. *(Medical Liability Monitor,* October 27, 1983, Vol, 8, No. 10)

DID YOU KNOW . . .

The United States Supreme Court on October 3, 1983, let stand an Illinois Supreme Court ruling that said two Chicago-area couples could not recover the costs of raising children born after sterilization procedures? It was the first time that the "wrongful birth" issue reached the nation's highest court. The justices dismissed the appeal without comment. *(Medical Liability Monitor,* October 27, 1983, Vol. 8, No. 10)

Reports from New York indicated that the JUA will request a 165 percent increase in malpractice insurance?

California and Missouri courts have ruled that osteopaths are prohibited from using the M.D. designation?

*This item from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse who are, respectively, Director of the Department and Director of Special Projects.

Board of Governors of the Medical Inter-Insurance Exchange of New Jersey has voted to file a rate request that will increase all professional liability rates through the Exchange by 13.7 percent effective February 1984?

POTENTIAL LEGAL PITFALLS LIE AHEAD FOR EMERGICENTERS

Use of the term "emergency" by freestanding emergency centers creates expectations that may expose the centers and their staff physicians to malpractice suits, medico-legal e perts say. Courts are likely to find for the plaintiff in cas involving a center's refusal to treat a patient whose conditio was too complicated, the lawyers say. In one such case, a emergicenter settled a suit by a family of a diabetic patie who died while being transferred to a hospital. Doctors an centers could get into more legal hot water is they fail t provide followup care, arrange appropriate referrals, o otherwise appear to abandon the patient. *(Medical Eco omics,* November 14, 1983)

The Medical Society of New Jersey

PRESENTS

MEDICAL MALPRACTICE SEMINARS

FOR AS LITTLE AS $45.00

Professional Liability and the Obstetrician/Gynecologist
Professional Liability and the Orthopedic Surgeon
Professional Liability and the Anesthesiologist
Professional Liability and the General Surgeon
Professional Liability and Internal Medicine
Neurosurgery and the Law

The Department of Professional Liability Control of the Medical Society of New Jersey has developed *professional liability video tapes aimed at specific medical specialties.* The video tapes incorporate a "talk show" format featuring James E. George, a physician-attorney, and physician(s) representing the medical specialty of the tape. Each of the 45-55 minute video tapes is designed to encourage postviewing discussion and is available for a $45.00 rental fee. All tapes are available in ¾ inch, Beta, and VHS.

TOPICS INCLUDE

- General assessments of professional liability
- Informed consent
- Multiple-physician consultants
- Medical records
- Physician to physician and physician to staff communications
- Group practice
- Emergency room setting
- Three "R's" of malpractice prevention

Category I AMA accreditation can be obtained if the video tapes are used as part of a planned program in conjunction with a moderator.

For more information please contact the Department of Professional Liability Control at the Medical Society of New Jersey, (609) 896-1766.

All tapes carry the copyright of MSNJ and may not be reproduced or distributed in any form or fashion without the express written consent of the Medical Society of New Jersey.

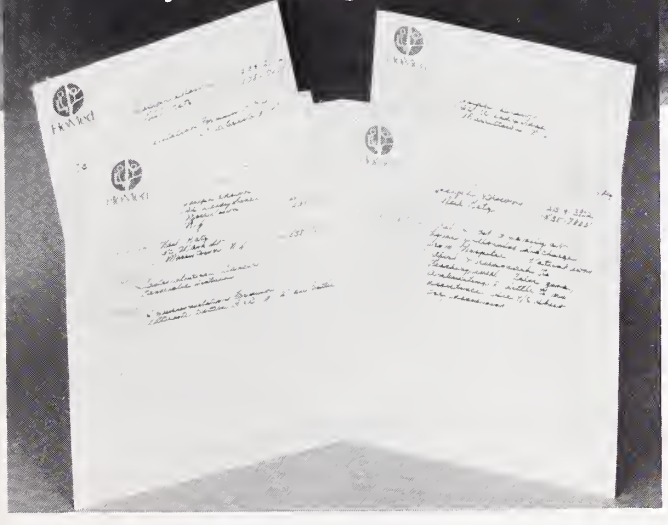
Copyright 1982.

THE BEST OF BOTH WORLDS UNDER DRG...

from Hospital Care to Home Care, HoMed Preserves the Physician/Patient Relationship by Ensuring the Continuity of Patient Care



Physician's Progress Reports



From the moment your homebound patient leaves the hospital, HoMed helps make the transition home a smooth one. Our experienced HEALTH CARE PROFESSIONALS are in continuous communication with the physician, providing progress reports, handling all the necessary paperwork and delivering products and services in all areas of HOME HEALTH CARE.

HoMed provides the kind of quality care you expect...keeping in mind that the physician/patient relationship is foremost in the continued care of the patient.

WHEN YOUR PATIENT NEEDS HOME HEALTH CARE...ONE CALL TO HoMed DOES IT ALL

- RESPIRATORY THERAPY PROGRAM
- FULL RANGE OF OXYGEN SYSTEMS
- PARENTERAL/ENTERAL NUTRITIONAL THERAPY
- CONVALESCENT & REHABILITATION EQUIPMENT
- EQUIPMENT REPAIRS
- BARRIER-FREE HOME MODIFICATION
- INFANTILE APNEA MONITORING

HoMed™...the Home Health Care Company

Serving the Medical Community

CALL TOLL FREE - NORTHERN N.J. (800) 452-9777 SOUTHERN N.J. (800) 392-6936
OUTSIDE NEW JERSEY CALL COLLECT - (201) 227-1800

JUST ONCE-DAILY FOR INITIAL THERAPY IN HYPERTENSION

Unique, once-daily formulation providing comprehensive cardiovascular protection

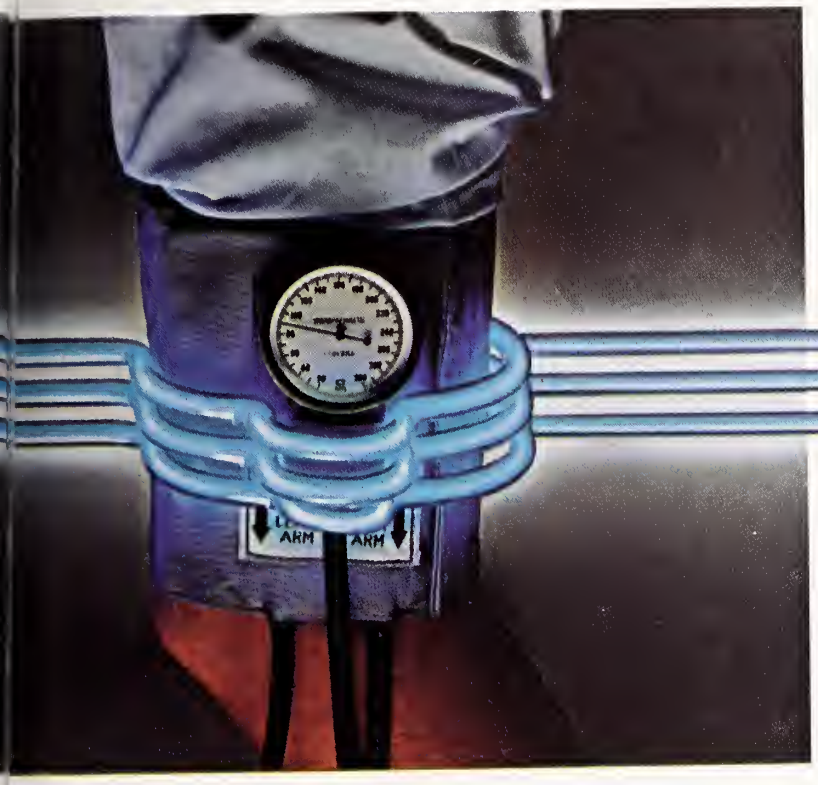
INDERAL LA offers the antihypertensive and cardiovascular benefits of INDERAL–with the additional advantage of convenient, single daily dosage. With a unique controlled-release formulation, INDERAL LA (propranolol HCl) provides sustained plasma levels and consistent, 24-hour beta blockade.

Smooth 24-hour blood pressure control

In controlled clinical studies, INDERAL LA effectively maintained systolic and diastolic blood pressure reductions with single daily dosing.

Avoids the potassium loss associated with diuretics

INDERAL LA controls blood pressure without the problem of hypokalemia often associated with long-term diuretic therapy. Like conventional INDERAL, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.



THE ONE TO COUNT ON

Start with 80 mg once daily...

Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. When converting patients from other beta blockers, including INDERAL tablets, start with the nearest milligram equivalent of INDERAL LA once daily and evaluate clinical results to determine if dosage adjustment is necessary. For arrhythmias, use conventional INDERAL (propranolol HCl) tablets.



80 mg 120 mg 160 mg

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

Please see next page for brief summary of prescribing information.

ONCE-DAILY

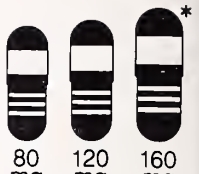
INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES

Ayerst®

The one to count on for HYPERTENSION, ANGINA and prevention of MIGRAINE.

ONCE-DAILY INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION SEE PACKAGE CIRCULAR.)*
INDERAL® LA BRAND OF propranolol hydrochloride
(Long Acting Capsules)
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta-blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking ther prior to major surgery is controversial. It should be noted, however, that the impaired abili the heart to respond to reflex adrenergic stimuli may augment the risks of general anesth and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of b receptor agonists and its effects can be reversed by administration of such agents, e dobutamine or isoproterenol. However, such patients may be subject to protracted se hypotension. Difficulty in starting and maintaining the heartbeat has also been reported beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the pearance of certain premonitory signs and symptoms (pulse rate and pressure changes acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be m difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidi Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of sympt of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function te

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have b reported in which, after propranolol, the tachycardia was replaced by a severe bradyca requiring a demand pacemaker. In one case this resulted after an initial dose of 5 propranolol.
PRECAUTIONS. General: Propranolol should be used with caution in patients with impai hepatic or renal function. INDERAL is not indicated for the treatment of hypertens emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patie should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal r lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disea elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as re pine should be closely observed if INDERAL is administered. The added catecholami blocking action may produce an excessive reduction of resting sympathetic nervous acti which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthost hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals h been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studie both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of signific drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dos levels. Reproductive studies in animals did not show any impairment of fertility that v attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic animal studies at doses about 10 times greater than the maximum recommended human do

There are no adequate and well-controlled studies in pregnant women. INDERAL sho be used during pregnancy only if the potential benefit justifies the potential risk to the fet

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised wh INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and ha rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block, hyp tension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of Raynaud type.

Central Nervous System. lightheadedness; mental depression manifested by insomn lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visi disturbances; hallucinations; an acute reversible syndrome characterized by disorientation time and place, short-term memory loss, emotional lability, slightly clouded sensorium, a decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrh constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with achi and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic. agranulocytosis, nonthrombocytopenic purpura, thrombocytoper purpura.

Auto-Immune. In extremely rare instances, systemic lupus erythematosus has be reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male imp tence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactio involving the skin, serous membranes and conjunctivae reported for a beta blocker (practol have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride ir sustained-release capsule for administration once daily. If patients are switched from INDER tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeu effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration m be necessary especially to maintain effectiveness at the end of the 24-hour dosing interv

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 n INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may l increased to 120 mg once daily or higher until adequate blood-pressure control is achieve The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 6 mg may be required. The time needed for full hypertensive response to a given dosage variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL L once daily, dosage should be gradually increased at three to seven day intervals until optimu response is obtained. Although individual patients may respond at any dosage level, t average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value ar safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few wee (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL L once daily. The usual effective dose range is 160-240 mg once daily. The dosage may b increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is n obtained within four to six weeks after reaching the maximum dose, INDERAL LA therap should be discontinued. It may be advisable to withdraw the drug gradually over a period several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE — At this time the data on the use of the drug in this age group a too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratorie

8688/88

Ayerst. AYERST LABORATORIES
New York, N.Y. 10017

EDITORIALS

Blood Banks and AIDS

The panic which has spread through our nation about cquired immunodeficiency syndrome (AIDS) has had sig-ificant real and imagined effects on blood banks, blood onors, and blood recipients.

In this issue (page 125), Smith, Brennan, and McDonough lebate the legal implications of refusal to accept blood dona-ions from Haitians, heroin addicts, and homosexuals, in erms of privacy, equal protection of the laws, constitutional ights, and public health. Their conclusions seem to offer omfort to the blood banks.

In order to provide equal comfort to recipients of blood ransfusions and to encourage the continued supply of blood o banks from donors who are not in the segments of the opulation which appear to be the exclusive carriers of AIDS, a statement was released to the public media by the Blood Banking Task Force for New Jersey.* The statement vas endorsed by the New Jersey State Department of Health nd the New Jersey Blood Bank Association, and was ap-roved by the Board of Trustees, MSNJ.

> Analysis of the data available from national and state public health authorities supports the conclusion that acquired immunodeficiency syndrome (AIDS) is not being spread by blood transfusions from voluntary donors. Appropriate public health measures are being employed by all blood collection facilities in the state of New Jersey.
>
> All blood transfused to patients in New Jersey is collected from volunteer blood donors. Additional screening methods currently employed in New Jersey include rigorous medical screening and the exclusion of donors who are at high risk of exposure to AIDS. These measures have been shown to be effective.
>
> One result of the excessive fears concerning possible transfusion-associated AIDS has been requests by patients for blood donors selected from family members, friends, or associates ("directed donors"). We agree with the American Association of Blood Banks, the American Red Cross, and the Council of Community Blood Centers, that: 'A system of directed donations may create intense pressure for family members and friends who may therefore be untruthful about their ability to meet donor requirements.' Therefore, we are concerned that such donations may be less safe than blood donated by volunteers at blood centers and hospitals, to meet the community's needs. Directed donations strongly are discouraged. Physicians can reassure their patients that the community's blood supplies are not considered a source of the spread of AIDS.
>
> People in good health, who are not members of groups known to be at high risk of exposure to AIDS, are urged to give blood to meet the needs of patients in New Jersey hospitals. Blood donation is carried out under strictly hygienic conditions, with sterile, new, disposable equipment, used only once for the donation. The donation is perfectly safe for the donor.

Physicians who refer persons to blood banks as donors or who order blood transfusions for their patients may wish to utilize the statement to answer questions on the subject.

A.K.

*Frank Campo, M.D., a member of the Board of Trustees, was MSNJ's liaison of the Task Force.

Sir Frederick G. Banting—The Artist

What did William Carlos Williams, M.D., and Sir Frederick G. Banting, M.D., have in common? They both were physicians, recipients of prestigious awards (Williams won the Pulitzer Prize and Banting won the 1923 Nobel Prize). artists, art collectors, and friends and admirers of artists.

Williams's artistic interest was international with headquarters in New York City. Banting, however, was parochial in his artistic taste, being limited primarily to Canada.

We were privileged to discover and borrow an original painting by Dr. Banting and to reproduce it as a cover for this issue. Readers are encouraged to learn more about Sir Frederick (pages 138-139) and to share our admiration for one who, like Williams, was able to utilize scientific and artistic talents for the betterment of mankind. A.K.

Baby Doe and the Prognosis Committee

A child is born; a child dies: is there another event more likely to bring to our eyes the tears of sorrow? It is not hard to understand that Baby Does born, living, dead, and yet to be born, elicit from health workers the desire to do all that can be done to alleviate suffering and preserve life. Our common humanity lays upon us the need to do what we can. Quality of care is our first consideration. Is it really?

In a recent issue of the "Physician Legal Bulletin" published in *The Journal,* George and Quattrone review some of the issues concerning when not to treat and when to allow life to end.[1] Should all available medical resources be marshaled for everyone? If not: How does one choose? Who chooses? What are the criteria of choice?

Costs of care for the child with serious abnormalities may be in excess of any family's ability to pay. One child who receives a liver transplant may use up all the funds available for the state of New Jersey, for a year, by legislative appropriation, for out-of-state hospital care. It has become recognized widely that if every person received all the benefits of health care, our country would not have enough money to pay for all.

If we are to live in a time of shortage, health care resources clearly will need to be allocated. How is this to be done? In some parts of the world, guns, physical strength, or money may determine resource allocation. Our country has gone far in the direction of equalizing access to health care. Some feel it has not gone far enough.[2] If there is not enough to go around, some individuals will be provided for and others will not. Whether or not we like the idea, our society has developed criteria to determine the outcome when individuals compete for satisfaction of needs. At present, outcomes are determined by: enthusiasm and skill of the physicians; vigor, social class, and resources of the patient or parents who conceived a child; cultural and ethical mores of the community in which all these persons live; and political, financial, and geographic situations of a particular state.

Is it fair to allow such results? Is it more in keeping with the historical policies of equality of opportunity of our country to develop more systematic methods for allocating care?

When an infant is born with serious congenital abnormalities (structural or physiological), attending physicians rapidly must determine what steps are needed to correct the problem. They must prognosticate the results of modern technological treatment. A child with deficient B and T cell function, delivered by an aseptic method into a sterile life-island, survives. Delivered vaginally, into even a clean nursery, the child dies. An infant with short gut syndrome survives with total parenteral nutrition. An infant with congenital hypothyroidism survives if detected early enough and is normal if treated properly. Sterile life-islands are available at only a few places in this country. Parenteral nutrition is offered at every tertiary care institution for infants, and in some secondary centers. Treatment for hypothyroidism should be available everywhere.

If the situation is complicated because the treatment i long, difficult, and expensive, it is unfair to offer treatmer without helping the family sustain the financial, educationa and emotional burden involved.[3]

If the situation is one in which the quality of life is suc as to cause a prudent person to doubt if it is worthwhil then we have Baby Doe. Now the situation has become ver comparable to that of the elderly—past all caring.[1] Much ha been made of the need for review of parental decisions, wit respect to the treatment to be offered children. Once, a chil was property, to be disposed of according to the wishes o the father. It is recognized now that the state may interven to protect children to see that they are given appropriat treatment, and to safeguard children from abuse or neglec It is but a small step between intervention upon notice o probable cause for suspicion (our current child abuse legis lation) and systematic examination of parental decision about a class of children (those with birth defects). Shoul all such instances be reviewed by an agency of government Are records to be opened? Privacy invaded? Parents' desire overruled, condemning them to later financial and emotiona bankruptcy? The decisions are not easy. The first Baby Do had Down's syndrome and intestinal obstruction. Treatmen was straightforward. Who is to say that the child witl Down's syndrome does not enjoy life, although the paren may find life more burdensome. The second had spina bifid and multiple defects. It is known that such children usuall are very severely retarded, immobile, and highly likely no to survive. One could describe anecdotes of case after case

There is a precedent known to almost every physician o a hospital staff: the prognosis committee.[1] Usually composec of several physicians with expertise in the specific illness an one or more neurologists or neurosurgeons, the committe reviews patients considered to have brain death, to determin when it is appropriate to advise the abandonment of effort to prolong life. It may be that members of the clergy or othe nonphysicians serve on such a committee. The principle o group wisdom to help the practitioner and the unhapp family in reaching a repugnant decision is well establishec and usually functions well.

Cannot such a precedent guide us in offering care to th seriously abnormal newborn, for whom the quality of lif under the most ideal circumstances may be compromised t an intolerable degree? The system may not be perfect, bu it works in many hospitals. Privacy is affirmed, the public is served, and the rights of infants, parents, and state ar protected.

Avrum L. Katcher, M.D.

REFERENCES

1. George JE, Quattrone M: Physician legal bulletin. *J Med Soc NJ* 80:12, 997.
2. Courter J: Time to act on organ transplants. *J Med Soc N* 80:12, 1052.
3. Will GF: *The Washington Post,* December 1983, p. A23.

Hospital Staff Privileges for Nonphysicians

The subject of hospital staff privileges for nonphysicians has been heating up over the last few years. More and more nonphysician professionals, including podiatrists, nurse midwives, and psychologists, have been attempting to gain medical staff privileges in order to practice their professions within the confines of the hospital.

Of necessity, these nonphysician professionals are unable, by virtue of their limited scope of training and licensure, to assume complete responsibility for the care of a patient as is the case for a licensed physician. Therefore, hospitals which have granted clinical privileges to these nonphysician professionals have had to create some medical staff oversight mechanism to review their cases while in the hospital or to coadmit to the combined service of the nonphysician and the oversight physician.

Many physicians have voiced their concern that these arrangements might expose them to liability for the negligent acts of the nonphysician professional. Hospitals, too, have voiced concern over nonphysician staff privileges because hospitals also know that they will be responsible in one form or another for the outcome of care rendered by these nonphysician professionals. A recent podiatric malpractice case clearly highlights the fact that everybody's anxieties in these areas are well-founded.

The case of Elam *v* College Park Hospital, 132 Cal.App.3d 332, was decided by the California Court of Appeals on June 25, 1982. In the patient's complaint, the plaintiff stated that a licensed podiatrist performed negligent podiatric surgery at the hospital to correct bilateral bunions and bilateral hammer toes. The patient was admitted to the hospital for surgery by the podiatrist and for treatment by a medical doctor member of the medical staff.

This admission to two professionals occurred pursuant to a hospital coadmission procedure requiring concurrence of the medical doctor before admitting the podiatric patient. It was not contested that the medical doctor had assumed responsibility for the overall medical care of that patient including the taking of the medical history and the performance of the physical examination to insure that podiatric surgery was not contraindicated.

The facts further revealed that the podiatrist was entirely an independent contractor with the hospital and never an employee or agent. The podiatrist never was paid by the hospital, operated his own office, and billed the patient directly. The patient in this case personally had selected the podiatrist for medical and/or surgical treatment. The podiatrist had complied with the hospital's credentialing process and the hospital's governing board granted him podiatric surgery privileges in April 1975. Apparently, the podiatrist had three other malpractice cases pending against him by the same plaintiff's attorney who represented the patient in the Elam case. The hospital in this case argued that it did not owe its patients a legal duty to exercise reasonable care in selecting, reviewing, and periodically evaluating the competency of the physicians and podiatrists it permitted to treat patients within its facilities. This argument was not well received by the court which cited numerous references underscoring the integrity of the doctrine of hospital corporate liability.

The court went on to conclude: "In summary, we hold a hospital as accountable for negligently screening the competency of its medical staff to insure the adequacy of medical care rendered to patients at its facility." The court went on to quote various provisions of the California Administrative Code, more particularly Title 22, section 70703 as follows: "(a) Each hospital shall have an organized medical staff responsible to the governing body for the fitness, adequacy, and quality of the care rendered to patients of the hospital; (b) The medical staff shall be composed of physicians and, where dental or podiatric services are provided, dentists or podiatrists."

Thus, the hospital cannot avoid liability for podiatrist members of its staff due to the hospital's overall responsibility as a corporate entity for what transpires within the hospital confines. Physicians also must be aware of the clear fact that they will be held accountable for any patient whom they have coadmitted with a nonphysician. Hospitals and medical staffs should exercise great care and caution in pursuing solutions to the problem of granting privileges to nonphysician professionals.

One thing is certain, however, and that is that an element of responsibility always will remain on the shoulders of the hospital and physician who are responsible for evaluating and overseeing the care rendered by these nonphysician professionals. J.E.G.

*The material for this column is coedited by Arthur Krosnick, M.D., Editor, *The Journal,* MSNJ; Vincent A. Maressa, J.D., Executive Director, MSNJ; and James E. George, M.D., J.D., Director of the Department of Professional Liability.

WHY AMA?

Through the AMA library you can have immediate access to a vast store of medical, scientific, and socio-economic information. The library maintains a large collection of books, journals, and microfilm and provides instant on-line access to countless information sources through computerized data bases. The AMA library: it's one more good reason why you should be a part of the AMA.

To Join,
Contact your county or state medical society or write: Division of Membership, AMA, 535 North Dearborn Street, Chicago, Illinois 60610 or call collect, (312) 751-6196.



References:
1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Us

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for th management of vasospastic angina confirmed by any of the following criteria: 1) classical patter of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm pro voked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patient who have had angiography, the presence of significant fixed obstructive disease is not incompatib with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDI may also be used where the clinical presentation suggests a possible vasospastic component bu where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion o in unstable angina where electrocardiographic findings are compatible with intermittent vasc spasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated fo the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrate or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance but confirmation of sustained effectiveness and evaluation of long-term safety in those patients ar incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA an beta blocking agents may be beneficial in patients with chronic stable angina, but available infor mation is not sufficient to predict with confidence the effects of concurrent treatment, especially i patients with compromised left ventricular function or cardiac conduction abnormalities. When in troducing such concomitant therapy, care must be taken to monitor blood pressure closely sinc severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect o PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tol erated hypotension. These responses have usually occurred during initial titration or at the time o subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug Interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request. © 1982, Pfizer Inc.

Pfizer LABORATORIES DIVISION
PFIZER INC.

"I can do things that I couldn't do for 3 yrs. including joining the human race again."



otes from an unsolicited
er received by Pfizer from an
gina patient.
ile this patient's experience
epresentative of many
solicited comments received,
all patients will respond to
cardia nor will they all
pond to the same degree.

83, Pfizer Inc.

"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

ocardia is indicated for the management of:
Confirmed vasospastic angina.
Angina where the clinical presentation suggests a possible sospastic component.
Chronic stable angina without evidence of vasospasm in tients who remain symptomatic despite adequate doses of eta blockers and/or nitrates or who cannot tolerate these gents. In chronic stable angina (effort-associated angina) ROCARDIA has been effective in controlled trials of up to ght weeks' duration in reducing angina frequency and creasing exercise tolerance, but confirmation of sustained fectiveness and evaluation of long-term safety in these tients are incomplete.

Please see PROCARDIA *brief summary on adjoining page.*

Postmyocardial Infarction Rupture of the Ventricular Septum

SHASHI K. AGARWAL, M.D., JACOB HAFT, M.D.,
JONATHAN GOLDSTEIN, M.D., Newark*

Cross-sectional echocardiography has acquired an important role in the evaluation of seriously ill patients with complicated myocardial infarction. The case presented illustrates the quick, accurate, and hazard-free capability of two-dimensional echocardiography for acute postmyocardial infarction septal rupture.

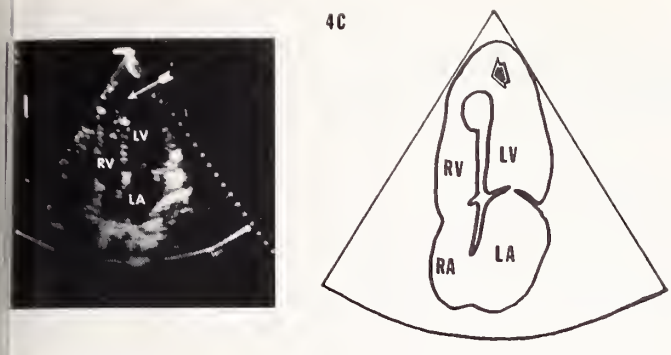
Cross-sectional echocardiography has allowed assessment of myocardial dysfunction in coronary artery disease.[1,2] It especially has been useful in recognizing complications of ischemia such as ventricular aneurysm,[3] ventricular rupture with pseudoaneurysm formation,[4] and papillary muscle dysfunction or rupture.[5] Since cross-sectional echocardiography visualizes the cardiac apex directly[6] where the majority of ischemia-related septal defects are located,[7] it has been extremely useful in diagnosis of postmyocardial infarction ventricular septal rupture.[8-10] We describe a case with ventricular septal defect complicating an acute myocardial infarction, diagnosed by cross-sectional echocardiography and confirmed by angiocardiography and cardiac surgery.

CASE REPORT

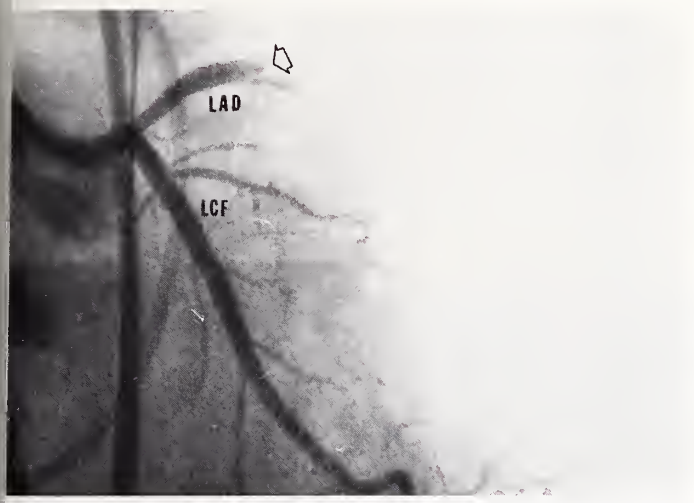
The patient was a 61-year-old white female, transferred to Saint Michael's Medical Center, Newark, for evaluation and further management after she was admitted to a nearby hospital with prolonged chest pain. Admission electrocardiograms and cardiac enzyme levels were consistent with an extensive acute myocardial infarction (MI). She did well for two days until the day prior to transfer, when she developed transient atrial fibrillation, and was treated with digitalis and furosemide. On the day of transfer, a harsh holosystolic murmur was audible for the first time over the precordium and was associated with a resting tachycardia of 122/min.

The patient's past history was remarkable only for hypertension, for which she had been on hydrochlorothiazide 25 mg daily for several years. There were no other known risk factors for coronary artery disease. On evaluation, the patient appeared to be comfortable in the supine position and afebrile. Pulse was regular at 95/min; blood pressure was 110/70 right arm; respirations were 18/min and unlabored. Jugular venous pulse was not distended and there was no peripheral edema. PMI was poorly felt; S1 and S2 were soft; S4 was present. A harsh grade III/VI holosystolic murmur was audible at the left sternal border without any definite radiation. Examination of the lungs, abdomen, and central nervous system was unremarkable. An electrocardiogram was consistent with a recent extensive anterior wall MI. Portable chest roentgenogram revealed a possible left lower lobe infiltrate. A bedside two-dimensional echocardiographic study showed akinesis of the entire left ventricle (LV) apex. The apical portion of the interventricular septum consistently was absent in several views. This was best seen on the apical four-chamber view (Figure 1). The free inferior portion of the interventricular septum further appeared bulbous suggesting marked edema. The LV and left atrium (LA) also were enlarged. A Swan-Ganz catheter was inserted percutaneously and revealed a step up at the right ventricle

*From the Department of Cardiology, Saint Michael's Medical Center, Newark. Correspondence may be addressed to Dr. Agarwal, Saint Michael's Medical Center, 306 High Street, Newark, NJ 07102.



gure 1—Two-dimensional echocardiogram; apical four-hamber view. Note the missing apical interventricular septum rrow). LV=left ventricle; RV=right ventricle; LA=left atrium; A=right atrium.



igure 2—Coronary angiogram. Note the total occlusion of the eft anterior descending (LAD) artery (arrow). The left circumflex rtery (LFC) appears clean.

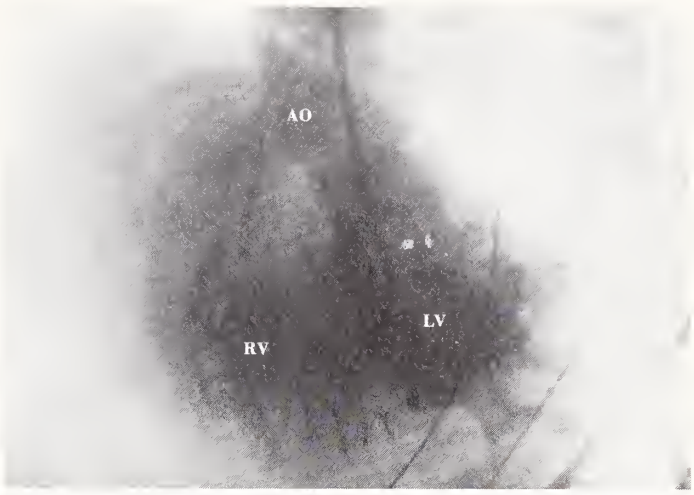


Figure 3—Left ventriculogram. The contrast is seen entering the right ventricle (RV) when injected into the left ventricle (LV). Ao =Aorta.

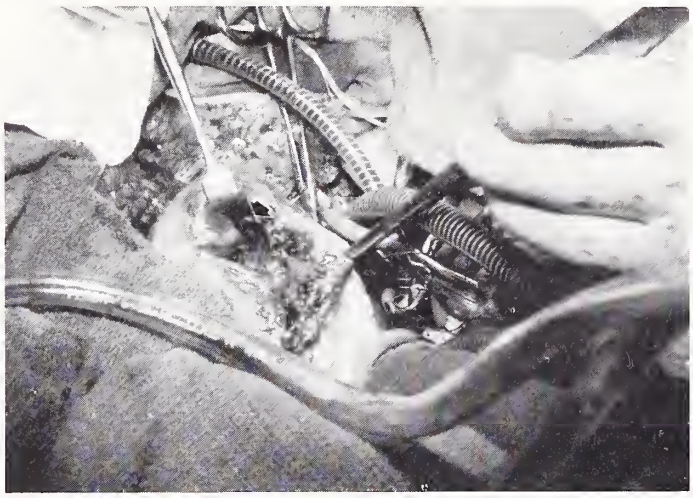


Figure 4—The arrow points to the ventricular septal defect as seen during surgery.

RV) level consistent with recirculation from the left heart to he right ventricle with a Qp/Qs ratio greater than 3:1. On ated acquisition of the blood pool scan, the LV was nlarged greatly with akinesis of the entire anteroseptal nferoapical wall. The LV ejection fraction was 17 percent. Cardiac catheterization revealed a large anterior septal and pical infarction with total occlusion of the left anterior descending artery in its proximal position (Figure 2). A large ventricular septal defect was recognized on left ventriculog-raphy (Figure 3). A guidewire mediated intraaortic balloon* was inserted percutaneously and the patient was operated on the following morning. At surgery, a large apical ventricular septal defect was confirmed. (Figure 4).

DISCUSSION

Ventricular septal rupture, a rare complication of acute myocardial infarction, is a serious event[11] with the majority occurring within the first week after infarction.[12] Clinical recognition often is difficult[13] but unremitting circulatory deterioration[14] may demand early surgery.[15] Further, recent data suggest an acceptable mortality (50 percent) with early surgical intervention in the unstable patient versus unacceptably high mortality (90 percent) with medical therapy of afterload reduction and intraaortic balloon pump once shock ensues.[16] Although cardiac catheterization may be performed in critically ill patients,[17] it imposes an increased risk. Bedside Swan-Ganz catheterization does not allow the site or size of the septal defect to be judged well.[18] This information is of importance to the surgeon.[14]

Several M-mode echocardiographic findings in ischemic septal rupture have been described[19-21] including dilatation of the right ventricle, early mitral valve opening or abnormal septal, and tricuspid valve motion. Rarely, septal discontinuity may be recognized.[22] Since these are nonspecific findings, an accurate assessment of the myocardial damage is lacking in this method.

Cross-sectional echocardiography, by providing spatial orientation, allows direct visualization of isolated ventricular septal defects.[23] By using several acoustic windows, the entire length of the interventricular septum can be viewed.[24] Left to right shunting may be inferred by negative contrast in the right ventricle using intravenous contrast echocardiography.[25] Further, recognition of an associated septal aneurysm or localization of the defect anteriorly or posteriorly easily can be made providing useful preoperative information.[14,26]

It is important that several sweeps be made from apical to basal and inferior to posterior areas to avoid a false negative study. Although technical dropouts may occur, correct adjustments of gain characteristics usually will allow defects as small as 5 mm to be visualized.[27]

*Kontron Cardiovascular, Inc., Everett, Massachusetts.

A false positive study due to echo dropouts from technical aberration should be excluded by recording the defect persistently in the same location on at least two separate two-dimensional views.

The most useful views have been parasternal short axis[8] and apical four chamber.[10,28] We recognized the defect best in the apical four-chamber view.

Cross-sectional echocardiography has acquired an important role in the evaluation of seriously ill patients with complicated myocardial infarction. The case presented in this report illustrates the quick, accurate, and hazard-free capability of two-dimensional echocardiography in diagnosing an acute postmyocardial infarction septal rupture.

REFERENCES

1. Niscon JV, Narahara KA, Smitherman TC: Estimation of myocardial involvement in patients with acute myocardial infarction by two-dimensional echocardiography. *Circulation* 62:1248-1255, 1980.

2. Meltzer RS, Woythaler JN, Buda AJ, et al.: Two-dimensional echocardiographic qualification of infarct size alteration by pharmacologic agents. *Am J Cardiol* 44:257-262, 1979.

3. Weyman AE, Peskoe SM, Welham ES, et al.: Detection of left ventricular aneurysm by cross-sectional echocardiography. *Circulation* 54:936-942, 1976.

4. Catherwood E, Mintz GS, Kotler MN, et al.: Two-dimensional echocardiography recognition of left ventricular pseudo-aneurysm. *Circulation* 62:294-303, 1980.

5. Fergenbaum H: *Echocardiography, 3rd Edition.* Philadelphia, PA, Lea and Febiger, 1981, pp. 469.

6. Hickman HO, Weyman AE, Wann LS, et al.: Cross-sectional echocardiography of the cardiac apex. *Circulation* 56:3:153, 1977.

7. Kaplan MA, Harris CN, Kay JH, et al.: Postinfarctional ventricular septal rupture: Clinical approach and surgical results. *Chest* 69:734-738, 1976.

8. Scanlan TG, Seward JB, Tajrk AJ: Visualization of ventricular septal rupture utilizing wide-angle two-dimensional echocardiography. *Mayo Clin Proc* 54:381-384, 1979.

9. Farcot JC, Borsante L, Rigand M, et al.: Two-dimensional echocardiographic visualization of ventricular rupture after acute anterior myocardial infarction. *Am J Cardiol* 45:370-377, 1980.

10. Sanders RJ, Kern WH, Blount SG Jr: Perforation of the interventricular septum complicating myocardial infarction. *Am Heart J* 81:736-748, 1956.

11. Giulian, ER, Danielson GK, Pluth JR, et al.: Postinfarction ventricular septal rupture: Surgical considerations and results. *Circulation* 49:455-459, 1974.

12. Dugall JC, Pryor R, Blount SG: Systolic murmur follow myocardial infarction. *Am Heart J* 87:577-583, 1974.

13. Kaplan MA, Harris CN, Kay JH, et al.: Postinfarctio ventricular septal rupture clinical approach and surgical resu *Chest* 69:734-738, 1976.

14. Dagget WM, Guyton RA, Mundth E, et al.: Surgery postmyocardial infarct ventricular septal defect. *Am S* 186:260-271, 1977.

15. Bardet J, Masquet C, Kahn JC, et al.: Clinical a hemodynamic results of intraaortic counterpulsation and surgery cardiogenic shock. *Am Heart J* 93:280-288, 1977.

16. Felner JM, Arenberg D, Meyer TP, Sympas PN, Schlant R Ventricular septal rupture and mitral regurgitation in a patient w an acute myocardial infarction. *Chest* 75:614-617, 1979.

17. Hill JD, Lary D, Kirth WJ, et al.: Acquired ventricular sep defects. *J Thorac Cardiovasc Surg* 70:440-450, 1975.

18. Meister SG, Helfant RH: Rapid bedside differentiation ruptured interventricular septum from acute mitral insufficiency. *Engl J Med* 287:1024-1025, 1972.

19. Chandraratra P, An-Balachandran PK, Shah PM, et a Echocardiography observations on ventricular septal rupture co plicating acute myocardial infarction. *Circulation* 51:506-510, 19

20. De Joseph RL, Seides SF, Linder A, et al.: Echocardiograph findings of ventricular septal rupture in acute myocardial infarctio *Am J Cardiol* 36:346-348, 1975.

21. Felner JM, Arenberg D, Meyer TP, et al.: Ventricular sep rupture and mitral regurgitation in patients with an acu myocardial infarction. *Chest* 75:614-617, 1979.

22. Kerin NJ, Edelstein J, DeRue RG: Ventricular septal defe complicating acute myocardial infarction. Echocardiographic der onstration confirmed by angiocardiograms and surgery. *Che* 70:560-563, 1976.

23. Seward JB, Tayrk AJ, Hagler DJ, et al.: Visualization isolated ventricular septal defect with wide-angle two-dimension sector echocardiography. *Circulation* 2:202, 1978.

24. Tayrk AL, Seward JB, Hagler DJ, et al.: Two-dimension real-time ultrasonic imagery of the heart and great vessels techniqu image orientation, structure identification, and validation. *May Clin Proc* 53:271-303, 1978.

25. Weyman AE, Wann LS, Hurwist RA, et al.: Negative contra echocardiography: A new technique for detecting left to right shun *Circulation* 111:11-26, 1977.

26. Gerayr FJ, Schwartz MJ, Bell AL: Postmyocardial infarctio ventricular septal tear syndrome. *Chest* 60:583-586, 1971.

27. King DL, Stieg CN, Ellis K: Visualization of ventricula septal defects by cardiac ultrasonography. *Circulation* 48:1215-122 1973.

28. Bishop HL, Gebson RS, Stann RB, et al.: Role of two dimensional echocardiography in the evaluation of patients wit ventricular septal rupture postmyocardial infarction. *Am Heart* 102:965-971, 1981.

OMPUTER CRUISE FOR DOCTORS

DAYS ON THE LUXURIOUS QUEEN ELIZABETH 2

DEPARTING FROM PHILADELPHIA MAY 12-20, 1984

- COMBINE BUSINESS WITH PLEASURE
- FUNDAMENTALS OF MICRO COMPUTERS
- UP-TO-DATE INFORMATION ON MEDICAL BUSINESS APPLICATIONS

ALL PROVIDED IN THE MOST SUPERB ACCOMMODATIONS ABOARD THE MOST LUXURIOUS SHIP AFLOAT – THE QUEEN ELIZABETH 2 – SAILING FROM THE PORT OF PHILADELPHIA MAKING STOPS AT BERMUDA – ST. THOMAS – ST. MARTIN.





WHO SHOULD ATTEND?

Doctors and professional staff with responsibility for cost ef tive operation of medical businesses should attend. Mi computers are changing the way the medical business opera At this seminar you learn how to cope with the microc puter explosion.

- LEARN TO RECOGNIZE APPROPRIATE OPPORTUNITIES FOR THE USE OF MICRO-COMPUTERS IN YOUR PRACTICE
- LEARN TO SELECT THE SOFTWARE THAT BEST MEETS YOUR SPECIFIC NEEDS
- BECOME ACQUAINTED WITH THE STRENGTHS AND WEAKNESSES OF PARTICULAR CLASSES OF SOFTWARE IN VARIOUS APPLICATIONS
- GAIN THE KNOWLEDGE YOU NEED TO EFFECTIVELY IMPLEMENT AND MANAGE MICROCOMPUTER USE

I. INTRODUCTION TO MICROS

DAY ONE –

- HARDWARE OVERVIEW
- SELECTING A MICRO
- INTRODUCTION TO SOFTWARE
- SELECTING SOFTWARE
- USING SOFTWARE

II. GETTING AHEAD WITH MICROS

DAY TWO -

- SELECTING A SYSTEM
- WORD PROCESSING

DAY THREE–

- WORD PROCESSING APPLICATIONS
- DATA BASE MANAGEMENT SOFTWARE

DAY FOUR–

- SPREADSHEET AND FINANCIAL ANALYSIS SOFTWARE
- ACCOUNTING SOFTWARE
- UNIQUE PROBLEMS OF MEDICAL SYSTEMS

III. KEEPING UP WITH NEW PRODUCTS

- MEDICAL SOFTWARE DEMONSTRATIONS

SEMINAR INSTRUCTORS

Peter Silvia has 12 years of experience using micros, minis and mainframes. As an assistant director i the New Jersey Governor's Management Improvement Program, he used mini computers to conduct major statewide program analysis. He assisted in development of statewide productivity measures re lating to use of mini and micro computers. Mr. Silvia is a quantitative economist (not a data processin professional) with more sensitivity to the barriers most often encountered in starting out in computers

James L. Lenz completed doctorate at the University of Pennsylvania in decision sciences (busines computers) 1978, M.B.A. Wharton School University of Pennsylvania in corporate and banking fin ances 1969, B.A. economics and psychology University of North Carolina Chapel Hill 1967. He is th original author of Extended Basic Language, High Density Data Compression Techniques, Genera Motors Financial Systems, Medical Insurance System. Author of C.B.O.E. On Line Data Base systems co-author of Micro Computers for Business Applications. Lecturer Wharton University of Pennsylvani 1968-1976 computer science.

QUEEN ELIZABETH 2

A FESTIVAL OF LIFE



















REGISTRATION PROCEDURES

- PLEASE COMPLETE ALL INFORMATION REQUESTED ON THE REGISTRATION FORM
- MAKE CHECK PAYABLE TO: P & A COMPANY—CUNARD FOR $400 PER PERSON DEPOSIT
- MAIL COMPLETED REGISTRATION FORM AND ACCOMPANYING CHECK TO P & A COMPANY, 29 TEE-AR PLACE, PRINCETON, N.J. 08540
- REGISTRATION DEADLINE: MARCH 1, 1984. ACCOMMODATIONS ON THE SHIP ARE ASSIGNED ON A FIRST COME-FIRST-SERVED BASIS
- CANCELLATION POLICY: CANCELLATIONS RECEIVED BY APRIL 11, 1984 WILL RECEIVE A FULL REFUND. CANCELLATIONS RECEIVED BETWEEN APRIL 12 AND APRIL 27 WILL RECEIVE A REFUND MINUS $100; BETWEEN APRIL 28 AND MAY 11 50%; NO SHOW/NO WRITTEN NOTICE—NO REFUND

WORKSHOP/CRUISE FEES

COMPUTER COURSE $500.00

CRUISE RATES (BASED ON DOUBLE OCCUPANCY) AT DISCOUNTED GROUP RATES PLUS PORT TAXES, PER PERSON

CATEGORY L	=	$1390
CATEGORY J	=	$1540
CATEGORY H	=	$1750
CATEGORY G	=	$1800
CATEGORY F	=	$1860
CATEGORY E	=	$1910

BROCHURES WILL BE SUPPLIED UPON RECEIPT OF RESERVATION FOR SELECTION OF CABIN CATEGORY, OR MAY BE REQUESTED IN ADVANCE BY MAIL OR TELEPHONE

609 452-2455

REGISTRATION APPLICATION

(Please type or print)

NAME _____ TELEPHONE (____) _____

NAME OF ACCOMPANYING SPOUSE OR COMPANION _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

AMOUNT ENCLOSED _____ DOLLARS (CHECK PAYABLE TO P&A COMPANY/CUNARD)

(SINGLE ACCOMMODATIONS ARE AVAILABLE, RATES WILL BE SUPPLIED UPON REQUEST)

(UP-GRADING OF CABINS WILL BE AVAILABLE ON A LIMITED BASIS)

MAIL COMPLETED APPLICATION FORM TO:

P & A COMPANY
29 TEE-AR PLACE
PRINCETON, NJ 08540

THIS IS NOT AN OFFER OR A CONTRACT. THE ATTENTION OF THE PASSENGER IS SPECIFICALLY DIRECTED TO THE TERMS FOR CARRIAGE OF PASSENGERS AS SET FORTH IN THE CUNARD PASSAGE CONTRACT, COPIES OF WHICH ARE AVAILABLE FROM CUNARD OR YOUR TRAVEL AGENT. British Registry Printed in USA

The First Clinical Year of Medical School

HENRY KRANZLER, M.D., KEVIN VITTING, M.D.,
RICHARD C. REYNOLDS, M.D., Piscataway*

Two medical students from UMDNJ-Rutgers Medical School kept diaries during their third-year clerkships in medicine, surgery, pediatrics, obstetrics-gynecology, and psychiatry. An analysis of the diaries provides a quantitative reflection on their experience and insight into their professional and personal maturation during this period of their medical education.

For most students, the third year of medical school is a series of clinical clerkships exposing them to an entirely new form of education and personal experience. During this year the focus of medical education is shifted from lectures, books, and classrooms to patients and hospitals.

The world of patient care makes new demands on the "doctor-in-training," who assumes an increasing amount of responsibility accompanied by anxiety. This also is a time for the third-year student to explore future career opportunities and perhaps to select a specialty. It is a period in which the student experiences a series of value conflicts that commonly go unresolved. The student wants to spend more time talking to patients, but is obligated to attend rounds. He/she sees patients undergoing painful procedures and, unsure of their appropriateness, is hesitant to question their utility.

A number of personal accounts of the years spent in medical school[1,2] and of the internship year[3] recently have appeared. These are the latest contributions to a growing literature on "the inner sanctum" of medical training and practice.[4] There also have been a number of reports which have sought to document quantitatively the use of time by medical students and residents,[5] as well as by a variety of medical practitioners.[6] These studies have relied upon the keeping of detailed diaries by the individuals involved.

This report combines quantitative observations with personal accounts and reflections on the third year of medical school. The material which follows is derived from diaries kept during the third year at UMDNJ-Rutgers Medical School (RMS).

METHODS

Rutgers Medical School has a traditional four-year curriculum. During the first two years, the student becomes familiar with the science of medicine, studying anatomy, physiology, pharmacology, biochemistry, microbiology, and pathology. He/she is exposed briefly to statistics, epidemiology, ethics, and selected topics in health economics and health care delivery. Near the end of the second year, in a course entitled, "Introduction to Clinical Medicine," the student learns the skills required for examining patients. The third year consists of 48 weeks of major clinical clerkships in pediatrics, psychiatry, and obstetrics-gynecology (8 weeks each) and in medicine and surgery (12 weeks each). These are offered at the major teaching hospital and affiliated institutions. Individual student schedules are formulated through a computerized matching system. The fourth year of medical school is largely a series of electives on various clinical services, except for obligatory rotations in family medicine (4 weeks), neurology (2 weeks), and ophthalmology and otolaryngology (1 week each).

The authors met several times prior to the third year to plan the format of the diaries, as well as to discuss expectations of the upcoming year. Throughout the third year of medical school, the authors met monthly to discuss the en-

*Dr. Reynolds is Dean, UMDNJ-Rutgers Medical School. Dr. Kranzler is a psychiatric resident, University of Connecticut. Dr. Vitting is a medical resident, Lenox Hill Hospital, New York. This paper was written while Drs. Kranzler and Vitting were medical students at UMDNJ. Correspondence may be addressed to Dr. Reynolds, UMDNJ-Rutgers Medical School, P.O. Box 101, Piscataway, NJ 08854.

tries. Once the year ended, the authors continued to meet in order to develop a summary of the experience and to assess the impact of the diary and discussions on that experience.

RESULTS

The results of the year-long personal review of the clinical clerkships are two kinds: quantitative and subjective.

Table 1 depicts the character of the individual clerkship. Student assignments to major clinical disciplines at RMS are comparable to other medical schools.[7] Within each student clerkship at RMS there is considerable similarity. Each clerkship is structured to include some didactic instruction. For example, the faculty of obstetrics-gynecology provides an extensive syllabus to the student and introduces the 8-week clerkship with 1 week of formal instruction. The 12-week medical clerkship includes a series of lectures on common medical problems.

The clinical clerkships are conducted in hospitals affiliated with RMS. Currently, Middlesex General-University Hospital is the primary teaching hospital of RMS and most students have a significant portion of their clerkships at this institution. Clerkships also are conducted at St. Peter's Medical Center, New Brunswick, The Medical Center at Princeton, and Muhlenberg Hospital, Plainfield. Psychiatric clerkships also use the Institute of Mental Health Sciences, Piscataway, and the Carrier Clinic, Belle Mead.

Table 2 provides the number of patients we actually examined during our third year of medical study. Other patients were seen and discussed at rounds, but we were involved in the care of the patients listed. We also have recorded the major procedures in which we participated during clerkships. There are little data to compare our clinical experiences with students enrolled in other schools.

The personal reflections from this year-long experience will be described.

Kranzler: I approached my third year of medical school with trepidation. I was concerned about being able to tolerate long hours, let alone function effectively with too little sleep. I was reluctant to become involved with the keeping of a journal, fearful that further demands on my time would detract from my personal life.

Nonetheless, I began the year with gusto. Pediatrics proved an ideal jumping-off point, for I enjoy children immensely. However, my earliest entries in the journal were to the point and involved little reflection, which I suspect was equally true of my performance on the ward. The following entry is illustrative: 'In the afternoon a 16-month-old girl was admitted for extreme hyperactivity, unwillingness to eat, and inability to sleep. The working diagnosis was that of toxic ingestion. After the child was taken to her room, her mother told me that she had to return home for a while to attend to her other child. I suggested that she carefully search her house for a clue regarding the substance apparently ingested by her daughter. She returned about an hour later with a vial of Cylert, a stimulant which had been prescribed for a neighbor's child. Given this information we were able to give the child chloral hydrate, which we had been reluctant to do for fear that she had ingested phenobarbital, a medication that had been prescribed for her father (September 11, 1980).' Though I was proud of having intervened successfully, the above description gave no hint of that fact.

As time passed and I became more confident in my role, my entries more accurately reflected my feelings, though I still strove faithfully to document what I saw and heard. One

TABLE 1
Weeks in Clinical Clerkships

Clerkship	Weeks	
	KV	HK
Pediatrics		
Lectures	1	1
Inpatient	3½	3½
Outpatient & Nursery	3½	3½
Psychiatry		
Adult	8	4
Adolescent	0	4
Obstetrics-Gynecology		
Lectures	1	1
Clinical Work	7	7
Medicine	12	12
Surgery		
General Surgery	6	6
Orthopedics	2	2
Urology	2	2
Anesthesia	1	1
Plastic Surgery	1	0

issue that I considered repeatedly as I wended my wa through the maze of medical specialties was the proper rol of technology in medical care. My first encounter with open heart surgery prompted me to write the following: 'Th environment in the operating room (OR) is technology a its unrestrained best. With the addition of some cardia monitoring equipment and a heart-lung machine, the roon became all the more mechanically surreal. The operation wa well underway before these feelings of mine gave way t intense concentration on the specifics of the procedure. Th pop music in the background prompted dance-like move ments on the resident's part, and at times he and the scrub nurse appeared to be almost dancing together as they moved to the music. Suddenly, a McDonald's commercial came blaring from the wall, and this, in the present context and mixed in my mind with earlier news comments concerning the attempted assassination of President Reagan, created a montage of America in the 1980s that was at once both curious and frightening. Though I wanted to share my thoughts with the others at the table, I suspected that they would not be receptive to my thinking aloud and I suppressed the urge. I refocused my attention on the now quivering mass of cardiac muscle which lay before me, buoyed in a sea of blood (March 31, 1981).'

Earlier in the year it had become apparent to me that the wonders wrought by medical technology often required that a price be paid: 'I watched amniocentesis performed on a 35-year-old black woman, for the purpose of genetic screening. The whole event was disturbing and it angered me because the woman was very frightened and she began crying and chanting in a foreign language. I later asked her where she was from and realized, when she said she was from West Africa, just how strange and culturally alien the whole experience must have been for her. It was at this point that I realized that my anger was due to the lack of concern for this person's psychic well-being that the people "caring" for her had demonstrated. Though some effort was made to calm her, it was apparent that she had not been prepared adequately beforehand. The sight of a half-dozen white people in white coats surrounding her and about to violate

TABLE 2
Number of Patients in Student Clerkship Experience

Patients Studied[1] or Followed[2]	KV	HK	Major Procedures	KV	HK
Pediatrics					
Inpatients studied:[1]	8	11	Cesarean		
followed:[2]	3	6	sections	1	3
Clinic Visits—illness:	12	17			
routine:	15	9			
Newborn examinations:	many				
Psychiatric					
Adults studied:	6	10	Electroconvulsive		
followed:	24	4	therapy	10	0
Adolescents studied:	0	10			
Cerebral Dysfunction Clinic	0	4			
Child Evaluation Conference:	0	1			
Obstetrics-Gynecology					
Inpatients studied:	29	31	Operations:	21	16
followed:	6	6	Deliveries		
Outpatients seen—Gyn	18	11	Vaginal:	15	11
Ob	26	30	Cesarean:	8	7
			Amniocenteses:	2	4
Medicine					
Inpatients studied:	27	28			
followed:	17	10			
Outpatients seen:	0	3			
Surgery					
Inpatients studied:	40	15	Operations		
followed:	many		Assisted:	87	42
Outpatients seen:	4	56	Observed:	8	17

[1]Patients "studied" received a complete history and physical examination and were followed with daily progress notes.
[2]Patients "followed" were seen regularly but only during part of their hospital stay.

her pregnant abdomen with a long needle was a virtual nightmare for her (January 22, 1981).'

As the year passed and I became more competent and comfortable in my role as a third-year medical student. I began to welcome the time I would spend each evening chronicling the day's events. I also looked forward to our monthly meetings, at which time we discussed our different experiences and the feelings they aroused. Eventually I realized that the journal and meetings enhanced my medical education by requiring that I reflect critically on my experience and by providing me with an opportunity to discuss my feelings with a fellow student and a senior faculty member.

Immersion in a strange environment, combined with stringent demands on one's time and energy, can result in feelings of panic and distraction. The continuity provided me by my regular journal entries contributed enormously to my perception that the many parts of specialized medicine do, in fact, comprise a unified whole. More than simply integrating experiences, the journal and monthly meetings provided me with an opportunity to make explicit many of the unspoken rules of clinical medicine and hospital conduct.

Vitting: My third year of medical school was more than a first pass with the many caricatures of disease—it was a challenge daring me to assume the role of the clinician. To do this required not only a conceptual and empirical data base, it depended on role models and a setting in which to imitate them.

I soon discovered that the character of my relationships with patients depended on my knowledge and experience in addressing what ailed them. At first, whenever I felt that they knew more than I did about their own diseases, I feared that my questions would betray my naivete. This was especially true in psychiatry. Sometimes a weary patient would ask me to go learn on someone else; usually, though, the barrier was a silent one. But, as my expertise and assertiveness mounted, I addressed an expanding repertoire of disease with increasing ease. Eventually, even very highly educated, private patients accepted my intrusion as necessary and beneficial to them as well as to me.

The impediment that I faced with some patients was characteristic of the environment of Rutgers Medical School. Unlike the circumstances at many established urban medical centers, most of our patients were highly educated and private. And they knew that medical students were not necessary for their care. The newness of our school itself presented another obstacle, for some patients and hospital staff were used to years of nonacademic medicine and did not see why this had to change. But our suburban setup did confer some benefits in that we studied in settings typical of those in which most of us someday will practice.

With time, my interaction with patients improved, as did my recording of their histories and physicals and both came to be motivated by a spirit of curiosity rather than a yearning for completeness. I began to know many of my patients as friends. Their clinical revelations enabled me to become fully involved in their care and, I hope, to add to the quality of care provided by those in charge. In this way, most patients

came to appreciate my participation in their care.

The teaching by the clinical faculty at RMS was enthusiastic. Most attendings took pains to be punctual and to emphasize what was important in their lectures and rounds. They shared their patients and techniques with me. I gave them a platform at the bedside for professing their art. They supported my fragile role as a fledgling clinician by trusting my findings and addressing me as "doctor."

I was initiated into the ancient rite of attending rounds early in pediatrics: 'I found that the demands of the attendings on rounds sometimes are hard to predict. At any point they might divert you and you may have to pick up and talk about any one detail while not losing your place in the presentation. You must appreciate the digressions, however, for they are almost always enlightening and memorable (October 7, 1980).'

By the time I finished my rotation in medicine my attitude had matured: 'I enjoyed the internists who derived great pleasure from recounting old clinical tales that contain a twist or a moral. They share the best cases collected over a lifetime, pouring them out like vintage wines, tasting them, and recorking them for the next time. And they love to hear the students presenting patients, provided that they take the pains to ensure accuracy and coherence (April 23, 1981).'

"Sometimes a weary patient would ask me to go learn on someone else; usually, though, the barrier was a silent one."

Another great tradition in which we participated was the oral examination, which is a natural and spontaneous extension of attending rounds. I felt it served as a much truer assessment of my abilities than did our written multiple-choice exams.

My interaction with the house staff was variable. Some of them were highly enthusiastic, humane, and instructive. With most of them I had an understanding that they would help me interpret the cases and learn what is really important if I would write the progress notes and do most of the routine procedures.

Being accessible, the residents served as more immediate role models than did the attendings. Some were exceptionally gallant and courteous to patients; some would skip seeing them and write down, WNL. Some were abrupt and callous toward patients and would even scorn me for stopping to talk to them. Some derided any patient who could not speak for himself: 'I find myself sometimes drifting into the residents' detachment. It seems we can speak more freely in the elevators when there are no laymen around, and when we turn a corner and walk through a gathering of worried relatives outside the ICU, we have to remember to resume a serious expression, reminding ourselves of the grave nature of our work. It is essential for the people to respect our work. And it is equally imperative for us to respect our work (April 2, 1981).'

I encountered a more altruistic spirit among the ancillary personnel—nurses, technicians, and social workers—who still seemed to react to the ravages of disease through the same eyes as its victims.

An important facet of my third-year experience was my clinical diary. At times, for the sake of the diary, I felt compelled to make time for my own rounds with patients, at which time I got to know their personalities and the illnesses on a more personal level and to record informatic about them for further reflection. From these anecdot there became a forum for my triumphs and frustration from which emerged a choice of career and a standard medicine.

Reynolds: As dean of the medical school I encouraged tw students to keep diaries and meet with me regularly to di cuss their clerkship experiences. I was interested in exact what took place in a clerkship: How many patients did student actually examine on each clerkship? How muc didactic teaching occurred? How was the student actuali involved in patient care? How many hours did the stude spend in the hospital? Most of these questions represente a quantitative description of the clerkship, information th surprisingly is difficult to find. In addition, I was curiou to try to understand how the student felt about the third yea of medical school. Most of us generalize from our earl clinical experiences and too commonly make pronounce ments and decisions from this point of reference. How doe the clinical maturation of medical students take place? Ho anxious is the student who begins a clerkship today? Wha exaggerates the uneasiness? How is stress handled?

The regular meetings with the two students helped t bridge the gap between the administrative and educationa processes. Medical schools now are complicated, sophisti cated institutions with many employees and large budgets It is all too easy for the dean of the medical school to becom detached from the education of medical students, the majo purpose of the school, and to have no personal under standing of their problems. Communication with medica students unfortunately is a task too often neglected by medi cal school administrators.

Reading regularly the diaries and meeting monthly witl the students did give me more knowledge and insight int the third-year clerkship experience. For the first time, I hac a detailed record of two students' experiences which prob ably are representative of students in the third year at RMS Of equal importance were the subjective analyses by thes students of their own clerkships.

Early in our discussions it was necessary to decide tha all remarks were made in confidence. It was not possible fo students to comment on their clerkships without a mixture of laudatory and derogatory remarks about faculty and pri vate attending physicians and hospitals. I also shared with the students my observations on the clinical education pro cess at Rutgers Medical School. I soon began to understanc from the student's perspective the fear of looking stupid. intimidation early in the clerkship by nearly everyone includ ing nurses and technicians as well as faculty, and the required commitment of hours and weeks during the successive clinical experiences.

I did not readily accept the students' complaints; they did not always agree with my explanations for some of their less than pleasant experiences. Unquestionably, we all profited from the exchange.

CONCLUSION

Kranzler and Vitting: During the third year of medical school, the maturation of our clinical skills followed a predictable course, which is memorable to every physician. The year was replete with new experiences and pressures. It demanded a substantial change in self-image. We came to appreciate our patients as something more than complex biological systems. By providing an opportunity for reflec-

n, our journals and regular discussions enhanced both our ofessional and personal development.

Though we recorded comparable numbers of clinical en-unters in similar settings, it is interesting to note the dif-ence in emphasis in our separate discussions. While one us was concerned with the impact of technology on the actice of medicine, the other focused on his own maturing ationships with patients and physicians. Our essays reflect r differing backgrounds and temperaments. They comple-nt each other to form a students' perspective on the first nical year of medical school.

Finally, keeping a journal has enabled us to compile an curate account of the clinical exposure gained in the con-t of a traditional third year. We expect that this enumer-on will stimulate efforts to define further this pivotal year medical education.

Reynolds: The process of meeting regularly with two in-ligent, sensitive medical students and discussing with them eir diary entries during the year of clinical clerkships gave me far more insight into this phase of medical education than the review of faculty program descriptions and student evaluations. I experienced the concomitant pleasure of watching two young medical students achieve clinical maturity as they progressed through their third year of medical school.

REFERENCES

1. Klein K; *Getting Better: A Medical Student's Story.* Boston, MA, Little, Brown and Co., 1981.
2. LeBaron C: *Gentle Vengeance.* New York, NY, Richard Mareck, 1981.
3. LaPalio LR: Time study of students and house staff on a university medical service. *J Med Educ* 56:61-64, 1981.
4. Shem S: *The House of God.* New York, NY, Dell, 1978.
5. Borgenicht L: American medicine: An annotated bibliography. *N Engl J Med* 304:1112-1117, 1981.
6. Mendenhall RC, Lloyd JS, Repicky PA, Monson JR, Girard RA, Abrahamson S: A national study of medical and surgical specialties: II. Description of the survey instrument. *JAMA* 240:1160-1168, 1978.
7. AAMC Curriculum Directory: 1982-83, Washington, D.C.


Leaving
the psychotic
symptoms of
Organic Brain
Syndrome
behind.



Effective

Treatment with Navane can produce improvement in psychotic symptoms such as hallucinatory behavior and unusual thought content as well as hostility, disorientation and depressive mood,[1,2] leaving the elderly patient more alert[2] and better able to participate in the activities of family life.

Well tolerated

Navane is generally well tolerated by elderly patients. Excessive sedation or drowsiness has been reported, but is uncommon.[1] Anticholinergic effects[3] and hypotension[4,5] are reported, but rarely. Should they occur, extrapyramidal symptoms can usually be readily controlled.

Navane®

(thiothixene) (thiothixene HCl)

Capsules 1 mg, 2 mg, 5 mg, 10 mg, 20 mg
Concentrate 5 mg/ml Intramuscular 2 mg/ml, 5 mg/ml

See following page for a brief summary of prescribing information

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
at the forefront of psychopharmacology

© 1982, Pfizer Inc

Navane®
(thiothixene) (thiothixene HCl)

References: 1. Util TM, Unverdi C. Wohlrade J, et al: Drug therapy of psychosis associated with organic brain syndrome. Presented as a Scientific Exhibit at the American Public Health Association Centennial, Atlantic City, New Jersey, November 12-16, 1972. 2. Katz MM, Util TM. Video methodology for research in psychopathology and psychopharmacology. *Arch Gen Psychiatry* 31:204-210, 1974. 3. Ketai R: Psychotropic drugs in the management of psychiatric emergencies. *Postgraduate Medicine* 58:87-93, 1975. 4. Birkett DP, Hirschfield W, Simpson GM. Thiothixene in the treatment of diseases of the senium. *Curr Ther Res* 14:775-779, 1972. 5. Data on file at Roerig.

BRIEF SUMMARY OF PRESCRIBING INFORMATION
Navane® (thiothixene) Capsules: 1 mg, 2 mg, 5 mg, 10 mg, 20 mg
(thiothixene hydrochioride) Concentrate: 5 mg/ml, intramuscular: 2 mg/ml, 5 mg/ml
Contraindications: Navane (thiothixene) is contraindicated in patients with circulatory collapse, comatose states, central nervous system depression due to any cause, and blood dyscrasias. Navane is contraindicated in individuals who have shown hypersensitivity to the drug. It is not known whether there is a cross-sensitivity between the thioxanthenes and the phenothiazine derivatives, but the possibility should be considered.
Warnings: *Usage in Pregnancy*— Safe use of Navane during pregnancy has not been established. Therefore, this drug should be given to pregnant patients only when, in the judgment of the physician, the expected benefits from the treatment exceed the possible risks to mother and fetus. Animal reproduction studies and clinical experience to date have not demonstrated any teratogenic effects.

In the animal reproduction studies with Navane, there was some decrease in conception rate and litter size, and an increase in resorption rate in rats and rabbits, changes which have been similarly reported with other psychotropic agents. After repeated oral administration of Navane to rats (5 to 15 mg/kg/day), rabbits (3 to 50 mg/kg/day), and monkeys (1 to 3 mg/kg/day) before and during gestation, no teratogenic effects were seen. (See Precautions.)

Usage in Children— The use of Navane in children under 12 years of age is not recommended because safety and efficacy in the pediatric age group have not been established.

As is true with many CNS drugs, Navane may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery, especially during the first few days of therapy. Therefore, the patient should be cautioned accordingly.

As in the case of other CNS-acting drugs, patients receiving Navane should be cautioned about the possible additive effects (which may include hypotension) with CNS depressants and with alcohol.

Precautions: An antiemetic effect was observed in animal studies with Navane, since this effect may also occur in man, it is possible that Navane may mask signs of overdosage of toxic drugs and may obscure conditions such as intestinal obstruction and brain tumor.

In consideration of the known capability of Navane and certain other psychotropic drugs to precipitate convulsions, extreme caution should be used in patients with a history of convulsive disorders or those in a state of alcohol withdrawal since it may lower the convulsive threshold. Although Navane potentiates the actions of the barbiturates, the dosage of the anticonvulsant therapy should not be reduced when Navane is administered concurrently.

Caution as well as careful adjustment of the dosage is indicated when Navane is used in conjunction with other CNS depressants other than anticonvulsant drugs.

Though exhibiting rather weak anticholinergic properties, Navane should be used with caution in patients who are known or suspected to have glaucoma, or who might be exposed to extreme heat, or who are receiving atropine or related drugs.

Use with caution in patients with cardiovascular disease.

Also, careful observation should be made for pigmentary retinopathy, and lenticular pigmentation (fine lenticular pigmentation has been noted in a small number of patients treated with Navane for prolonged periods). Blood dyscrasias (agranulocytosis, pancytopenia, thrombocytopenic purpura), and liver damage (jaundice, biliary stasis) have been reported with related drugs.

Undue exposure to sunlight should be avoided. Photosensitive reactions have been reported in patients on Navane.

Neuroleptic drugs elevate prolactin levels; the elevation persists during chronic administration. Tissue culture experiments indicate that approximately one-third of human breast cancers are prolactin dependent *in vitro*, a factor of potential importance if the prescription of these drugs is contemplated in a patient with a previously detected breast cancer. Although disturbances such as galactorrhea, amenorrhea, gynecomastia, and impotence have been reported, the clinical significance of elevated serum prolactin levels is unknown for most patients. An increase in mammary neoplasms has been found in rodents after chronic administration of neuroleptic drugs. Neither clinical studies nor epidemiologic studies conducted to date, however, have shown an association between chronic administration of these drugs and mammary tumorigenesis; the available evidence is considered too limited to be conclusive at this time.

Intramuscular Administration— As with all intramuscular preparations, Navane Intramuscular should be injected well within the body of a relatively large muscle. The preferred sites are the upper outer quadrant of the buttock (i.e. gluteus maximus) and the mid-lateral thigh.

The deltoid area should be used only if well developed, such as in certain adults and older children, and then only with caution to avoid radial nerve injury. Intramuscular injections should not be made into the lower and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.

Adverse Reactions: *Note:* Not all of the following adverse reactions have been reported with Navane (thiothixene). However, since Navane has certain chemical and pharmacologic similarities to the phenothiazines, all of the known side effects and toxicity associated with phenothiazine therapy should be borne in mind when Navane is used.

Cardiovascular effects: Tachycardia, hypotension, lightheadedness, and syncope. In the event hypotension occurs, epinephrine should not be used as a pressor agent since a paradoxical further lowering of blood pressure may result. Nonspecific EKG changes have been observed in some patients receiving Navane. These changes are usually reversible and frequently disappear on continued Navane therapy. The incidence of these changes is lower than that observed with some phenothiazines. The clinical significance of these changes is not known.

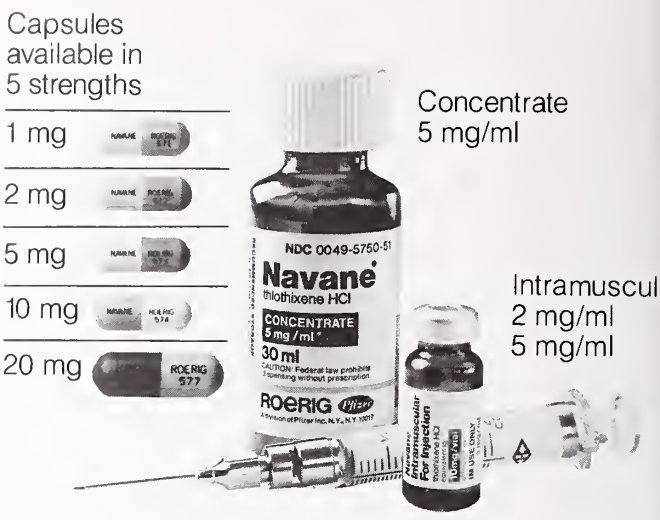
CNS effects: Drowsiness, usually mild, may occur although it usually subsides with continuation of Navane therapy. The incidence of sedation appears similar to that of the piperazine group of phenothiazines, but less than that of certain aliphatic phenothiazines. Restlessness, agitation and insomnia have been noted with Navane (thiothixene). Seizures and paradoxical exacerbation of psychotic symptoms have occurred with Navane infrequently.

Hyperreflexia has been reported in infants delivered from mothers having received structurally related drugs.

In addition, phenothiazine derivatives have been associated with cerebral edema and cerebrospinal fluid abnormalities.

Extrapyramidal symptoms, such as pseudo-parkinsonism, akathisia, and dystonia have been reported. Management of these extrapyramidal symptoms depends upon the type and severity. Rapid relief of acute symptoms may require the use of an injectable antiparkinson agent. More slowly emerging symptoms may be managed by reducing the dosage of Navane and/or administering an oral antiparkinson agent.

Persistent Tardive Dyskinesia: As with all antipsychotic agents tardive dyskinesia may appear in some patients on long term therapy or may occur after drug therapy has been discontinued. The risk seems to be greater in elderly patients on high-dose therapy, especially females. The symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Sometimes these may be accompanied by involuntary movements of extremities.



There is no known effective treatment for tardive dyskinesia; antiparkinsonism agents usu not alleviate the symptoms of this syndrome. It is suggested that all antipsychotic age discontinued if these symptoms appear.

Should it be necessary to reinstitute treatment, or increase the dosage of the agent, or swit different antipsychotic agent, the syndrome may be masked.

It has been reported that fine vermicular movements of the tongue may be an early sign syndrome and if the medication is stopped at that time, the syndrome may not develop.

Hepatic effects: Elevations of serum transaminase and alkaline phosphatase, usually tran have been infrequently observed in some patients. No clinically confirmed cases of jau attributable to Navane (thiothixene) have been reported.

Hematologic effects: As is true with certain other psychotropic drugs, leukopenia leukocytosis, which are usually transient, can occur occasionally with Navane. Other antipsyc drugs have been associated with agranulocytosis, eosinophilia, hemolytic anemia, t bocytopenia and pancytopenia.

Allergic reactions: Rash, pruritus, urticaria, photosensitivity and rare cases of anaphylaxis been reported with Navane. Undue exposure to sunlight should be avoided. Although not e enced with Navane, exfoliative dermatitis and contact dermatitis (in nursing personnel) have reported with certain phenothiazines.

Endocrine disorders: Lactation, moderate breast enlargement and amenorrhea have occ in a small percentage of females receiving Navane. If persistent, this may necessitate a redu in dosage or the discontinuation of therapy. Phenothiazines have been associated with positive pregnancy tests, gynecomastia, hypoglycemia, hyperglycemia, and glycosuria.

Autonomic effects: Dry mouth, blurred vision, nasal congestion, constipation, increased s ing, increased salivation, and impotence have occurred infrequently with Navane the Phenothiazines have been associated with miosis, mydriasis, and adynamic ileus.

Other adverse reactions: Hyperpyrexia, anorexia, nausea, vomiting, diarrhea, increase in a tite and weight, weakness or fatigue, polydipsia and peripheral edema.

Although not reported with Navane, evidence indicates there is a relationship bet phenothiazine therapy and the occurrence of a systemic lupus erythematosus-like syndrom

NOTE: Sudden deaths have occasionally been reported in patients who have received ce phenothiazine derivatives. In some cases the cause of death was apparently cardiac arre asphyxia due to failure of the cough reflex. In others, the cause could not be determined nor c it be established that death was due to phenothiazine administration.

Dosage and Administration: Dosage of Navane should be individually adjusted depending o chronicity and severity of the condition. In general, small doses should be used initially gradually increased to the optimal effective level, based on patient response.

Some patients have been successfully maintained on once-a-day Navane therapy.

Usage in children under 12 years of age is not recommended because safe conditions for its have not been established.

Navane Intramuscular Solution: Navane For Injection— Where more rapid control and treatr of acute behavior is desirable, the intramuscular form of Navane may be indicated. It is als benefit where the very nature of the patient's symptomatology, whether acute or chronic, ren oral administration impractical or even impossible.

For treatment of acute symptomatology or in patients unable or unwilling to take oral medica the usual dose is 4 mg of Navane Intramuscular administered 2 to 4 times daily. Dosage ma increased or decreased depending on response. Most patients are controlled on a total d dosage of 16 to 20 mg. The maximum recommended dosage is 30 mg/day. An oral form sh supplant the injectable form as soon as possible. It may be necessary to adjust the dosage w changing from the intramuscular to oral dosage forms. Dosage recommendations for Nav (thiothixene) Capsules and Concentrate appear in the following paragraphs.

Navane Capsules: Navane Concentrate— In milder conditions, an initial dose of 2 mg three ti daily. If indicated, a subsequent increase to 15 mg/day total daily dose is often effective.

In more severe conditions, an initial dose of 5 mg twice daily.

The usual optimal dose is 20 to 30 mg daily. If indicated, an increase to 60 mg/day total d dose is often effective. Exceeding a total daily dose of 60 mg rarely increases the benef response.

Overdosage: Manifestations include muscular twitching, drowsiness, and dizziness. Symptom gross overdosage may include CNS depression, rigidity, weakness, torticollis, tremor, salivat dysphagia, hypotension, disturbances of gait, or coma.

Treatment: Essentially is symptomatic and supportive. For Navane oral, early gastric lavag helpful. For Navane oral and Intramuscular, keep patient under careful observation and main an open airway, since involvement of the extrapyramidal system may produce dysphagia respiratory difficulty in severe overdosage. If hypotension occurs, the standard measures managing circulatory shock should be used (I.V. fluids and/or vasoconstrictors.)

If a vasoconstrictor is needed, levarterenol and phenylephrine are the most suitable dru Other pressor agents, including epinephrine, are not recommended, since phenothiazine der tives may reverse the usual pressor action of these agents and cause further lowering of the bl pressure.

If CNS depression is present and specific therapy is indicated, recommended stimula include amphetamine, dextroamphetamine, or caffeine and sodium benzoate. Stimulants t may cause convulsions (e.g. picrotoxin or pentylenetetrazol) should be avoided. Extrapyrami symptoms may be treated with antiparkinson drugs.

There are no data on the use of peritoneal or hemodialysis, but they are known to be of little va in phenothiazine intoxication.

ROERIG Pfize
A division of Pfizer Pharmaceutic

Is There an Indigenous Viral Flora in Man?

FRANK J. MICHALSKI, Ph.D., Newark*

Does man have a normal viral flora in the same way that he has a bacterial flora? Although pertinent data are scarce, available data suggest a negative response. Many types of viruses can be found in the human body; so far, no symbiotic function as occurs with bacteria has been shown.

The question of a viral flora has been asked by physicians and medical students during lectures on the diagnosis of viral infections in humans. A computer search of the literature revealed no papers specifically addressed to this question. Isenberg and Painter stated discussion of virus carriage in healthy individuals has been omitted because of the paucity of pertinent information.[1] In this paper, an attempt will be made to document the data available and to answer this intriguing question.

Indigenous is defined as produced, growing, or living naturally in a particular region or environment. Another word with a slightly different meaning that sometimes is used instead of indigenous is endogenous, which means growing on the inside or originating within the body. As applied to bacteriology, these definitions have a twofold meaning. One is the location in or on the human body and the second is an implied lack of harm due to their presence, i.e. living naturally. Almost every microbiology textbook contains a chapter[1-4] on indigenous bacteria in humans: "The body of man becomes infected from the moment of birth, and a variety of species establish a more or less permanent residence on or even in the superficial tissue. Here, they usually are symbiotic and benefit the host in a number of ways. Some of their actions however, may not be beneficial, and when the general resistance of the host is sufficiently depressed they may even cause disease."[2]

Infection with viruses may take place at birth, such as the highly lethal neonatal herpes simplex infection, or even before birth as congenital rubella or cytomegalovirus (CMV) infection. The consequence of most of these acute, lytic virus infections is disease of varying severity. Another type of virus infection not as greatly researched and written about is the persistent virus infection which, in some cases, can cause disease without any apparent cytopathology.[5] Therefore, in contrast to bacteria, most viral infections are not symbiotic and do not benefit the host. So, the term indigenous as applied to bacteria may not apply to viruses in the second meaning as being helpful. In the other meaning, viruses may be found in the body and this usually is referred to as persistent or latent infections.

Much has been written about persistent or latent virus infections and many definitions have been brought forward. Melnick defines latent virus infection as viral persistence in the absence of clinical symptoms.[6] The virus might or might not be in a proviral or a negative state, and virus particles might or might not be produced. Rapp defines persistent infection as one in which infectious virus continually is released even in the presence of circulating antibody and in the absence of symptoms of disease.[7] A latent infection is one in which at least the genome of the virus is present, but infectious viruses cannot be recovered except during episodes of overt disease. So, with reference to infection with viruses, the term persistent or latent would be better than the term indigenous as used for bacteria.

Almost all types of animals that have been used for virus research have been found to harbor latent, indigenous, or, as it often is referred, endogenous viral flora.[8-14] These include chickens, mice, rats, rabbits, hamsters, dogs, cats, guinea pigs, and monkeys. The fact that these animals harbor

*Dr. Michalski is affiliated with the Diagnostic Virology Laboratory, Saint Michael's Medical Center. Correspondence may be addressed to Dr. Michalski, Saint Michael's Medical Center, 268 High Street, Newark, NJ 07102.

numerous types of indigenous viruses would seem to make it likely that man also harbors indigenous viruses. So far, testing of human tissues has found few viruses which would be considered indigenous.[15] There are viruses in the human body, in some circumstances, that could be considered indigenous. These viruses can be isolated or identified using either standard diagnostic virology methods or special biochemical techniques. Some could be considered as persistent infections with virus shedding for long periods and, in some, the virus can be reactivated from a latent stage somewhere in the body.

If you search a human body for viruses at a time of no overt illness, what viruses might you find? The Table shows a list of possible candidates for human indigenous viruses grouped by type of nucleic acid, either DNA or RNA. This list does not pretend to be inclusive and other viruses yet to be discovered may have to be added later.

TABLE

Candidates for Human Indigenous Viruses

DNA	RNA
Hepatitis B	Entero
BK and JC	Polio
	Coxsackie A
Adeno	Coxsackie B
	Echo
Human herpesviruses	
	Measles
Herpes simplex type 1	
Herpes simplex type 2	Retro
Varicella-zoster	
Cytomegalovirus	Human type C leukemia
Epstein-Barr	Foamy

First on the list is hepatitis B because the virus sometimes can remain in the blood for years after primary infection as a chronic persistent infection in the absence of overt disease.[16-18] This virus causes clinical serum hepatitis, but sometimes there is liver damage leading to cirrhosis or even carcinoma. The virus sometimes can be found in the liver and in the urine. Since the virus cannot be grown in cell culture, diagnosis relies on the detection of antigen or antibody by serodiagnostic methods such as radioimmune assay (RIA) or enzyme linked immunosorbent assay (ELISA). The body responds to infection with production of antibodies to the various antigens of hepatitis B, namely hepatitis B surface antigen ($Hb_s A_g$), hepatitis B core antigen ($Hb_c A_g$), or hepatitis B e antigen. Some of these antibodies can persist for life and in some populations 5 to 20 percent of healthy adults have antibody to $HBSA_g$. Posttransfusion hepatitis primarily is carried by non-A, non-B hepatitis virus. Much research now is in progress on the non-A, non-B hepatitis virus, but preliminary results suggest it may be similar to hepatitis B.

BK and JC, members of the papovavirus family, were put on the list because they can be reactivated from latency in an unknown part of the body; they are found in the urine of immunosuppressed patients, especially those with renal transplants.[19,20] The only disease associated with these viruses is progressive multifocal leukoencephalopathy (PML). JC virus has been isolated from brain tissue of PML patients. Infection with these viruses is common since 70 to 80 percent of human sera tested was found to contain antibody.

Adenovirus, of which there are 34 different human serotypes, often can be isolated from healthy human tissue, such as the adenoidal or tonsillar tissue of most children.[21,22] Respiratory disease, pharyngitis, and external disease of the eye are caused by adenovirus infection, although most infections are subclinical. There may be persistent intermittent excretion of virus following clinical or subclinical infection. The antibodies that arise to these viruses persist for life.

All five types of human herpesviruses were put on the list because latency is a characteristic of all herpesvirus infections.[23] The oral strain of herpes simplex type 1 causes gingivostomatitis as a primary infection in young children, although many infections are subclinical. Keratitis and sometimes encephalitis can follow type 1 infection. The genital strain of herpes simplex type 2 produces lesions in the genital organs and is spread by sexual contact. Babies infected at birth acquire neonatal herpes with a lethality of 71 percent. By adulthood, 70 to 90 percent of the population have antibodies to herpes simplex. The virus persists in th human body latent state in vertebral and sacral ganglior Spontaneous recurrences of lesions are prompted by stres on the body.[24]

Varicella-zoster virus causes chickenpox, a commo disease of skin and mucous membranes of children. Eight percent of the population have antibody to V-Z.[25] The viru remains latent in the body in the nuclei of dorsal nerv ganglion similar to the way HSV does. Reactivation of laten infection by trauma over the age of 45 leads to inflammator reaction of posterior nerve roots and ganglion, wit dermatomal distribution of skin lesions known as shingle or zoster.

Cytomegalovirus has caused an inapparent infection in 8(percent of the population by 35 years of age.[26] Infectior during embryonic development sometimes causes severe congenital abnormalities. Virus most easily is isolated from the urine, but where it is latent in the human body is no known. It may be in the leucocytes. It has been isolated from adenoids and has been found in salivary glands of 10 to 33 percent of autopsies on children. Fifty to 80 percent of the population have antibodies to CMV. Often, the virus is reactivated during immunosuppression, as in kidney transplant patients.

Epstein-Barr virus, the most recently discovered human herpesvirus, causes primary infection which mainly is subclinical in children, but infection of young adults can lead to mononucleosis.[27] Ninety percent of adults have antibodies to EB virus, and it remains latent in the body somewhere in the leucocytes. Stress can cause reactivation.

First on the list of RNA viruses is the enterovirus group, which consists of the polio (3 types), coxsackie A (23 types), coxsackie B (6 types), and echo (33 types) viruses. They were placed on the list because they can cause infection of the alimentary canal in the absence of disease.[28] Most infections are subclinical, but when disease is produced, it can include poliomyelitis, acute respiratory infection, aseptic meningitis, herpangina, pleurodynia, hand, foot, and mouth disease, and pericarditis. A large percentage of the population has antibodies to many of these strains. Following a disease-producing infection, virus can remain in the alimentary canal for long periods, two to four weeks.

Measles virus was included because it sometimes can remain after primary clinical infection and then lead to the chronic neurological disease subacute sclerosing panencephalitis (SSPE).[29] Virus can be found in lymph nodes and in the brain tissue. A large percent of the population has

antibodies to measles. German measles, or rubella, a member of the Toga virus group was not placed on the list, although in congenitally infected infants, the virus may persist for several years.

Retroviruses had to be included because many of them are true endogenous viruses, having the viral genome integrated into the cellular genome as a provirus.[30] In this way, endogenous means that viral genetic information is a constant part of the genetic constitution of an organism. Many vertebrate animals including chickens, mice, cats, and baboons possess endogenous virus sequences. Man also may possess endogenous virus sequences,[31] but most of the endogenous viruses have a very low disease-producing potential. The majority have not yet been demonstrated to transform cells in vitro or to be oncogenic in vivo. Recently, the first human type C retrovirus has been isolated from T lymphocytes of leukemia patients.[32] Another retrovirus that previously had been found in human cell culture is foamy virus. It has not been associated with disease so far.

CONCLUSION

Many types of human viruses can be found in different parts of the human body in the apparent absence of disease. The function, if there is any, has yet to be discovered. Most virologists would not consider them to be a normal flora. In fact, the retroviruses, which in some cases can become intimately connected to the cellular genome, are more truly indigenous or endogenous than are the bacteria. Therefore, the answer to the intriguing question which was posed in the introduction is that there are human indigenous viruses, but most people would not consider them to be a normal viral flora as comparable to the normal bacterial flora.

REFERENCES

1. Isenberg HD, Painter BG: Indigenous and pathogenic microorganisms of humans, in Lennette EH, Spaulding EH, Truant SA (eds): *Manual of Clinical Microbiology.* Washington, D.C., American Society of Microbiology, 1980, pp. 25-29.

2. Davis BD, Dulbecco R, Eisen H, Ginsberg H (eds): *Microbiology, 3rd Edition.* Harperstown, MD, Harper and Row, Inc., 1980, pp. 808-810.

3. Jawetz E, Melnick J, Adelberg EA: *Review of Medical Microbiology.* Los Altos, CA, Lange Medical Publication, 1980, pp. 283-286.

4. Joklik W, Willett HP: *Zinsser-Microbiology.* New York, NY, Appleton-Centrury-Crofts, 1976, pp. 404-411.

5. Oldstone MB: Immunopathology of persistent viral infections. *Hospital Practice* 17:61-72, 1982.

6. Melnick JL: Latent viral infections in donor tissues and in recipients of vaccines, in *Cell Cultures for Virus Vaccine Production.* National Can. Inst. Monograph 29, 1968, pp. 337-353.

7. Rapp F, Jerkofsky MA: Persistent and latent infections, in Kaplan AS (ed): *The Herpes Viruses.* New York, NY, Academic Press, 1973, pp. 271-289.

8. Luginbuhl RE: Viral flora of chick and duck tissue sources, in *Cell Culture for Virus Vaccine Production.* Nat. Can. Inst. Monograph 29, 1968, pp. 109-118.

9. Kniazeff AJ: Viruses infecting cattle and their role as endogenous contaminants of cell culture, in *Cell Culture for Virus Vaccine Production.* Nat. Can. Inst. Monograph 29, 1968, pp. 123-132.

10. Gillespie JH: Viral flora of canine tissue, in *Cell Culture for Virus Vaccine Production.* Nat. Can. Inst. Monograph 29, 1968, pp. 113-139.

11. Wilner BJ: Viral flora of rabbits, in *Cell Culture for Virus Vaccine Production.* Nat. Can. Inst. Monograph 29, 1968, pp. 141-148.

12. Hull RN: Viral flora of primate tissue, in *Cell Culture for Virus Vaccine Production.* Nat. Can. Inst. Monograph 29, 1968, pp. 173-175.

13. Hsiung GD: Detection of latent virus in kidney tissue, in *Cell Culture for Virus Vaccine Production.* Nat. Can. Inst. Monograph 29, 1968, pp. 351-357.

14. Hsiung GD: Endogenous viral contaminants in animal tissue, in *Diagnostic Virology-Illustrated by Light and Electron Microscopy.* New Haven, CT, Yale University Press, 1982, pp. 252-262.

15. Kalter SS, Hebesky RL: Viral flora of tissue sources-simian and human, in *Cell Culture for Virus Vaccine Production.* Nat. Can. Inst. Monograph 29, 1968, pp. 149-160.

16. Gitnick G: Non-A, non-B hepatitis, in *Perspective on Viral Hepatitis.* Abbott Diagnostic Monograph, Chicago, IL, Abbott Laboratory, 1981.

17. Hoofnagle JH: Types A and B viral hepatitis, in *Perspectives on Viral Hepatitis.* Abbott Diagnostic Monograph, Chicago, IL, Abbott Laboratory, 1981.

18. Perillo RP: The hepatitis viruses: Differential diagnosis, in *Perspective on Viral Hepatitis,* Abbott Diagnostic Monograph, Chicago, IL, Abbott Laboratory, 1981.

19. Padgett BL, Walker DL: New human papovaviruses. *Prog Med Virol* 22:1, 1976.

20. Gardner SD, Field AM, Coleman DV, Huline B: New human papovavirus (B.K.) isolated from urine after renal transplantation. *Lancet* 1:1253, 1971.

21. Rowe WP, Heubner RS, Gilmore LK, Parrot RH, Ward TC: Isolation of a cytopathogenic agent from human adenoids undergoing spontaneous degeneration in tissue culture. *Proc Soc Exp Biol Med* 84:570, 1953.

22. Ginsberg HS: Adenoviruses, in Davis BD, Dulbecco R, Eisen H, Ginsberg H: (eds): *Microbiology, 3rd Edition.* Harperstown, MD, Harper and Row, Inc., 1980, pp. 1048-1060.

23. Nahmias AJ, Roizman B: Infection with herpes simplex viruses 1 and 2. *N Engl J Med* 286:667, 1973.

24. Rawls WE: Herpes simplex virus types 1 and 2 and herpes virus simiae, in Lennette EH, Schmidt NJ (eds): *Diagnostic Procedures for Viral Rickettsial, and Chlamydial Infections.* Washington, D.C., American Public Health Association, 1979.

25. Weller TH: Varicella and herpes zoster, in Lennette EH, Schmidt NJ (eds): *Diagnostic Procedures for Viral, Rickettsial, and Chlamydial Infections.* Washington, D.C., American Public Health Association, 1979, pp. 375-398.

26. Weller TH: The cytomegaloviruses: Ubiquitous agents with protein clinical manifestations (2 parts). *N Engl J Med* 285: 203, 1971.

27. Henle W, Henle G, Howritz CA: Infectious mononucleosis and Epstein-Barr virus associated malignancies, in Lennette EH , Schmidt NJ (eds): *Diagnostic Procedures for Viral Rickettsial and Chlamydial Infections.* Washington, D.C., American Public Health Association, 1979, pp. 441-470.

28. Melnick JL, Wenner HD, Phillips CA: Enteroviruses, in Lennette EH, Schmidt NJ (eds): *Diagnostic Procedures for Viral, Rickettsial, and Chlamydial Infections.* Washington, D.C., American Public Health Association, 1979, 471-534.

29. Black FL: Measles, in Evans AS (ed): *Viral Infections of Humans, Epidemiology and Control.* New York, NY, Plenum Medical Books, 1976, p. 297.

30. Dulbecco R: Oncogenic viruses, in David BD, Dulbecco R, Eisen H, Ginsberg H: *Microbiology, 3rd Edition.* Harperstown, MD, Harper and Row, 1980, pp. 1231-1261.

31. Bonner TS, Connell CO, Cohen M: Cloned endogenous retroviral sequences from human DNA. *Pro Natl Acad Sci* 79: 4709-4713, 1982.

32. Popvic M, Sarin PS, Robert-Gurroff M, Kalyanaraman US, Mann D, Minowoda J, Gallo RC: Isolation and transmission human retrovirus (human T-cell leukemia virus). *Science* 219: 856-859, 1983.

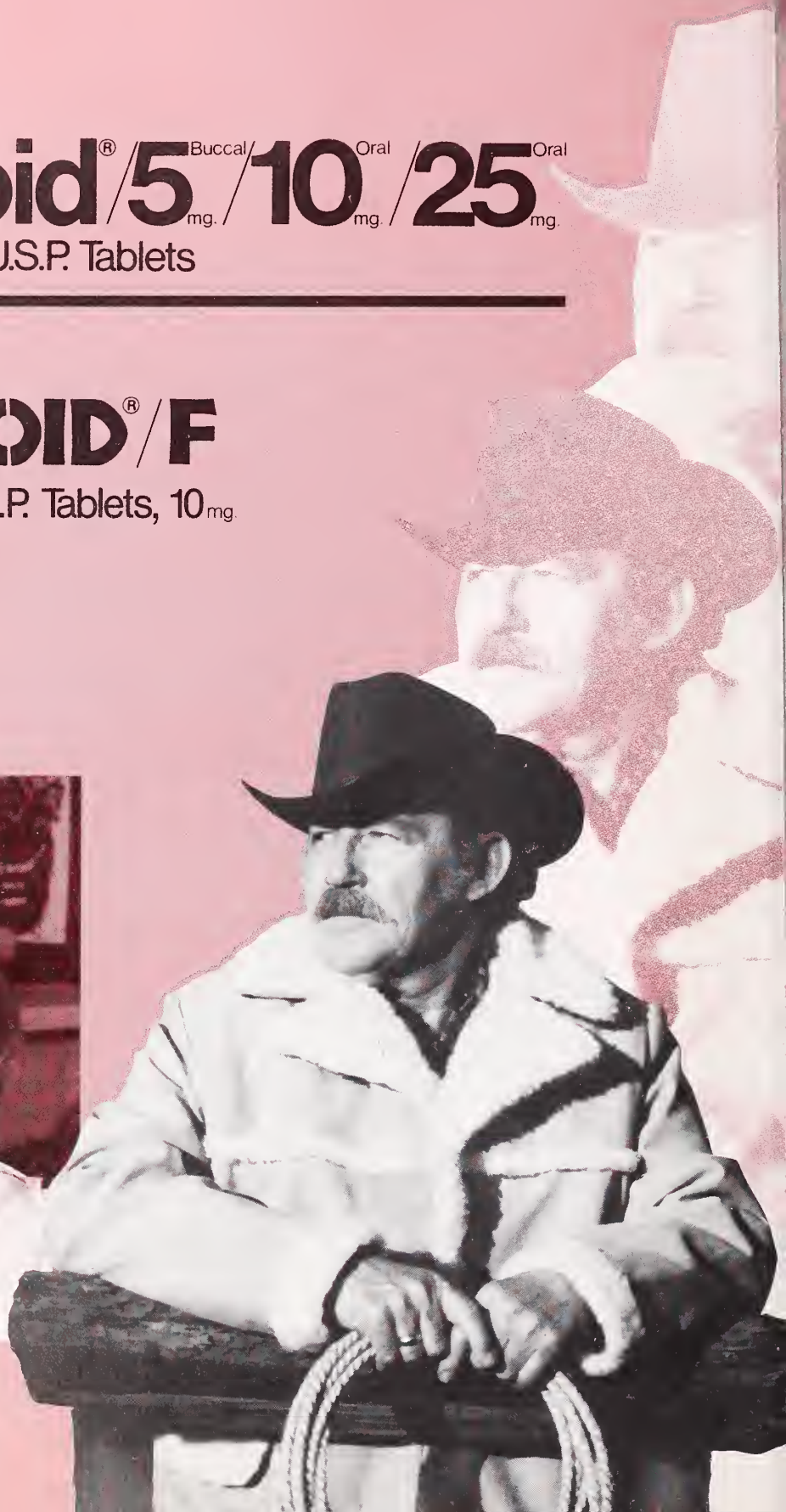
BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android®/5 mg. Buccal/10 mg. Oral/25 mg. Oral
Methyltestosterone U.S.P. Tablets

ANDROID®/F
Fluoxymesterone U.S.P. Tablets, 10 mg.





May a Blood Bank Refuse Donations To Prevent the Spread of AIDS?

LEON G. SMITH, M.D., RICHARD BRENNAN, LL.D.,
BRIAN McDONOUGH, J.D., Newark*

The cause of acquired immunodeficiency syndrome (AIDS) is unknown. One hypothetical pathogenetic mechanism is transfusion of blood donated by a victim of AIDS in a latent period. It is not possible now to screen AIDS-infected blood by testing samples on an individual basis, but screening donors from the dominant segments of the population which are exclusive carriers of AIDS (homosexuals, Haitians, and illicit drug users) is possible. The authors believe blood donation facilities have a right and duty to ask suitable questions to screen such donors. The legal questions of the individual's right to privacy, equal protection under the law, and the public health are discussed.

This article will explore the legal and constitutional implications of attempting to contain the spread of acquired immunodeficiency syndrome (AIDS) by refusing blood donations from certain groups of donors based on their ancestry, drug habits, and sexual orientation.

CASE REPORT

A 65-year-old heterosexual male, who was not a Haitian nor a drug user, had coronary bypass surgery 18 months prior to his admission. His chief complaints were cough, fever, and chills for a week. The patient received ampicillin at home for one week before admission. His physical examination was negative except for a macular papular drug eruption due to ampicillin. Chest x-ray and arterial blood gas levels were normal. Subsequently, he developed a positive diffuse gallium scan of the lung and later a diffuse infiltrate of the entire lung. Lung biopsy revealed *Pneumocystis carinii*. The patient died despite proper sulfamethoxazol-trimethoprim therapy.

The patient never had used any illicit drugs. He was not exposed to anyone with AIDS. The donors of the blood he received were reexamined and all were well. One donor had been a heroin user, but never volunteered this information. He was not questioned about drug use, homosexuality, or Haitian background for privacy reasons.

LEGAL RAMIFICATIONS

What are the legal ramifications of a case such as this? One may start by asking what civil liability a blood bank or a hospital-run blood donation facility might have violated in a lawsuit brought by the patient's estate or survivors. It is settled law in New Jersey that a blood bank cannot be liable for unsafe blood under a theory of strict liability, that is, absolute liability simply by virtue of its blood being unsafe and having caused this man's death. The facility can only be held liable if its failure to detect the unsafe qualities in the blood was due to a want of reasonable care on its part and thereby negligent.[1] The blood donation facility may argue that it cannot be found negligent because the state of the art, to our knowledge, does not allow blood samples to

*Dr. Smith is Director, Department of Medicine, Saint Michael's Medical Center, Newark. Mr. Brennan and Mr. McDonough are affiliated with Shanley & Fisher, Newark. Correspondence may be addressed to Dr. Smith, Department of Medicine, Saint Michael's Medical Center, 268 High Street, Newark, NJ 07102.

be tested individually to detect the presence of AIDS. Were this case that simple, the blood bank probably could not be accused of negligence just as blood banks could not be found negligent in the days when it was impossible to detect serum hepatitis in the blood.

However, it is not that simple. While it may not be possible to screen AIDS-infected blood by testing samples on an individual basis, it nevertheless is possible to screen AIDS-infected blood by screening donors from those segments of the population which are the dominant, if not exclusive, carriers of AIDS: homosexuals, Haitians, and drug users. Given the uncanny tendency of AIDS to confine itself to these segments of the population, an argument could be fashioned that the blood bank's failure to inquire into these traits was a lack of reasonable care and, therefore, negligent.

This forces the blood bank into a painful position. If it does not ask questions about homosexuality, Haitian origin, or drug use, it runs a serious risk of civil liability for negligently accepting and supplying unsafe blood. If it does ask these questions, it will be prying into the private affairs of its donors. In the case of homosexuals and Haitians, it also would face the unpleasant task of rejecting applicants based solely on sexual orientation or national origin. Understandably, blood bank personnel fear that they would be acting illegally and intruding on the rights of these groups to privacy and to equal protection of the laws.

Any fear by the blood banks of invading the constitutional rights of its donors would not be well founded as a matter of constitutional law. It is true that the past 20 years have witnessed an unprecedented expansion of the individual's right to privacy and to equal protection of the laws. However, even the most valued rights to privacy and equal protection must yield to the overpowering public interest in freedom from disease and epidemic. Just as one's right to free speech does not entitle him or her to yell fire in a public theatre,[2-6] one's right to be left alone does not entitle him or her to infect the neighbors and community with deadly and infectious diseases. If there are ways of preventing this epidemic without invading the privacy and equal protection rights of the infecting individual, these means should be used. However, if the disease cannot be controlled any other way than by infringing on these freedoms, then it is submitted that they may be infringed upon.

This principle was set down by Justice Harlan of the United States Supreme Court in *Jacobson v Massachusetts,*[3] a turn-of-the-century case which pitted the rights of a man who did not want to be vaccinated against the need of his community to protect itself from smallpox. After noting that every state and community has the right to take such measures as are necessary to protect the general health and common welfare of its citizens, the court turned to Jacobson's argument that this interest was not so compelling as to justify invading his bodily integrity through vaccination or invading his liberty through fine or imprisonment for failure to be vaccinated:

> The defendant insists that his liberty is invaded when the State subjects him to fine or imprisonment for neglecting or refusing to submit to vaccination; that a compulsory vaccination law is unreasonable, arbitrary and oppressive, and, therefore, hostile to the inherent right of every freeman to care for his own body and health in such a way as to him seems best; and that the execution of such a law against one who objects to vaccination, no matter for what reason, is nothing short of an assault upon his person. But the liberty secured by the Constitution of the United States to every person within its jurisdiction does not import an absolute right in each person to be, at all times and in all circumstances, wholly freed from restraint. There are manifold restraints to which every person is necessarily subject for the common good. On any other basis organized society could not exist with safety to its members. Society based on the rule that each one is a law unto himself would soon be confronted with disorder and anarchy. Real liberty for all could not exist under the operation of a principle which recognizes the right of each individual person to use his own, whether in respect of his person or his property, regardless of the injury that may be done to others. This court has more than once recognized it as a fundamental principle that persons and property are subjected to all kinds of restraints and burdens, in order to secure the general comfort, health, and prosperity of the State; of the perfect right of the legislature to do which no question ever was, or upon acknowledged general principles ever can be made, so far as natural persons are concerned. . . . In *Crowley v Christensen,* 137 U.S. 86, 89, we said: The possession and enjoyment of all rights are subject to such reasonable conditions as may be deemed by the governing authority of the country essential to the safety, health, peace, good order, and morals of the community. Even liberty itself, the greatest of all rights, is not unrestricted license to act according to one's own will. It is only freedom from restraint under conditions essential to the equal enjoyment of the same right by others. It is then liberty regulated by law.[4]

Nor did Justice Harlan even consider the potential merits of Jacobson's argument that the Massachusetts legislature was wrong in its assumption that vaccination would prevent or lessen the incidence of smallpox. As long as the state had not acted arbitrarily and unreasonably in enabling communities to require vaccination of their members as a safeguard against smallpox, the court declined to second guess the legislature by evaluating the medical evidence anew and deciding whether the legislature was correct. It was enough that it had not been arbitrary or unreasonable and that there was a real and substantial relation between the means used, in that case vaccination, and the end sought, that of safeguarding the general health.[5]

So strong was the compelling public interest in the general health that the court refused to exempt Jacobson from the vaccination requirement by virtue of his subjective fear that vaccination would endanger his health, a fear that was based on his son's and his own severe childhood reactions to a vaccination. In rejecting even this deeply felt argument, the court answered resoundingly that "[W]e are not prepared to hold that a minority, residing or remaining in any city or town where smallpox is prevalent, and enjoying the general protection afforded by an organized local government, may thus defy the will of its constitutional authorities, acting in good faith for all, under the legislative sanction of this state. If such be the privilege of a minority, then a like privilege would belong to each individual of the community, and the spectacle would be presented of the welfare and safety of an entire population being subordinated to the notions of a single individual who chooses to remain a part of that population."[6]

The lesson of *Jacobson v Massachusetts* is clear: the health

ınd safety of the entire community are paramount to the privacy and even the bodily integrity of one individual who nay infect that community. Like draft registration and taxes, his limitation on one's freedom is an inevitable price of enjoying society's other protections.

Indeed, prospective blood donors who either are homosexual or Haitian would pay a lesser price than did the individual in *Jacobson.* In that case, a citizen was forced either to have a smallpox vaccine injected into his body or face fine, imprisonment, or both. In this case the only cost would be the invasion of privacy all donors would suffer from being asked about their sexual orientation and, if they were black, about their national origin. The embarrassment and rejection a homosexual or Haitian would feel by being singled out and turned away from a blood donation facility are real. The need to protect the lives and health of potential donors nevertheless should take precedence judging by the past teachings of the Supreme Court.

We see no indication that the principles set forth in *Jacobson* have diminished over time. While cases involving contagious and infectious disease thankfully have dwindled due to medical science, courts still reaffirm these principles at every opportunity. Local laws requiring that school children be vaccinated as a condition of their enrollment have been uniformly upheld even over objections that they violated religious liberty.[7-11] So strong is this commitment to the preservation of life and health that courts and the state have not hesitated to intervene in family relationships when necessary to save the life of a spouse or a child over religious objections, even when no threat of contagion to others is involved.[12] While this power normally is reserved to the individual states, it may be exercised when necessary by the federal government as demonstrated by the late 1970s swine flu program.

Should this notion of paramount government power to protect the general health have too absolutist a ring to it, we hasten to point out that this right is not unfettered. In closing his decision in *Jacobson,* Justice Harlan assured that the court could interdict the law or regulation where its enforcement would be "so arbitrary and oppressive in particular cases as to justify the interference of courts to prevent wrong or oppression." Had the petitioner been able to show with "reasonable certainty," rather than generalized fear, that vaccination would endanger his health or well-being then the court suggested the result would have been different.[13] Likewise, were it possible to screen out AIDS-contaminated blood without invading the privacy of donors or subjecting them to unequal treatment, then a court might find that the donation facility should pursue that less intrusive course. However, we are aware of no effective and acceptable method by which blood can be tested to detect the presence of AIDS. Until medical science reaches that stage, there is simply no other way to protect the lives of prospective donors other than by making some necessary inroads into the rights of Haitians and homosexuals.

One might rejoin that the right of privacy and of equal protection have come a long way since *Jacobson* and today Justice Harlan so unequivocally would not have subordinated the right of the individual to the right of the community to defend itself against disease. While eight decades of constitutional law might have altered Justice Harlan's analysis, we doubt that it would have changed the result.

The constitutional right of privacy undoubtedly has come a long way since 1904. Today we recognize a constitutional right of privacy in matters of contraception,[14] procreation,[15] sterilization,[16] and even death[17]—rights that were unheard of in 1904. It is unclear, however, whether one's sexual orientation falls within this constitutionally recognized zone of privacy. While compelling arguments can be made that this intensely personal matter should be constitutionally protected against outside interference, it is an open question whether the federal courts would be ready to take this step given their acquiescence in statutes outlawing private consensual homosexual acts,[18-19] requiring the separation of homosexuals from the armed forces,[20,21] and otherwise diminishing the protections available to homosexuals.[21-24] However, given the liberal tradition of New Jersey courts in carving out new human rights under the aegis of the common law and the New Jersey state constitution, we see a viable possibility that they would recognize such a right.[25-27]

"Even the most valued rights to privacy and equal protection must yield to the overpowering public interest in freedom from disease and epidemic."

Were the right of privacy to sexual orientation to be granted, however, to what extent would that right be invaded by asking someone to state sexual orientation as a precondition to giving blood? The due process clause protects one against being deprived of his right to privacy, but this burden on privacy does not appear to deprive the donor of the right to live his or her own lifestyle or place an intolerable burden on that lifestyle. Moreover, even the right to privacy may at some point have to give way to other compelling state interests. For example, we recognize a constitutional right to privacy in deciding whether or not to have an abortion, but require that interest to yield to the compelling state interest in protecting potential life during the final trimester of pregnancy.[28]

Another constitutional concern is whether turning homosexuals and Haitians away from a blood donation facility would violate their constitutional rights to equal protection of the law.[29] We do not believe it would. Communities and legislatures inevitably must draw distinctions between different groups of people, bestowing or withholding certain benefits on the basis of age, geography, financial status, and sex. Such practices comply with the equal protection clause as long as they bear a real and substantial relation to a legitimate state objective,[30] a test which most laws would be hard pressed not to meet. In this case it hardly can be disputed that refusing blood from homosexuals and Haitians bears a real and substantial relation to a legitimate community objective, that of protecting the public from contagious disease.

However, any law which singled out Haitians or homosexuals for adverse treatment might be examined with a more exacting eye. In recent years courts have held that any law which discriminates on the basis of a suspect classification will be subjected to strict scrutiny and upheld only if it is necessary to achieve a compelling state objective and if there are no less intrusive means available for achieving that objective. Not many classifications qualify as "suspect," and the courts thus far have limited this category to classifications

based on race, nationality, alienage, or religion.[31-34] Haitians would qualify for this higher level of "strict scrutiny" in that they are being singled out on the basis of nationality (it is questionable whether discrimination against them would be classified as being based on race or alienage, in that non-Haitian blacks or aliens still would be permitted to donate blood). No courts have found homosexuals to be a suspect class and several have declined to do so.[35]

Also, a law which does not discriminate on the basis of race, nationality, or alienage nevertheless may be subject to strict scrutiny if it imposes a direct and substantial burden on a fundamental right, such as the right to privacy.[36,37] Were sexual orientation included within the constitutional right to privacy, which we have concluded is open to debate, it is an interesting question whether refusal to accept blood donations by homosexuals would be a direct and substantial burden on their right to their own lifestyle. While the financial inconvenience of being unable to donate to a commercial facility may be minimal, one nevertheless may feel degraded and stigmatized if a blood bank refused to take one's blood for transmission to the rest of the populace. If this seems frivolous, imagine how Catholics or Jews might feel if a blood bank capriciously refused to accept their blood as unfit for injection into the populace at large. The difference between this case and that hypothetical, of course, is that a blood bank fearful of spreading AIDS to its donors is acting not out of caprice but out of a duty to protect the lives of its donees.

Therefore, even if homosexuals as well as Haitians were found to be a suspect class, or if refusal to accept homosexuals' blood did directly burden their right to privacy, we believe that they still could be rejected by blood banks because their exclusion is absolutely necessary to achieve what may be the most compelling of all compelling state interests, the protection of the public health by limiting the spread of AIDS.

In analyzing the constitutional implications of this dilemma, we have to some degree put the cart before the horse. We have assumed throughout this discussion that the blood donation facility would be capable of violating the constitution. This brings to the fore the constitutional concept known as "state action."

It is rudimentary constitutional law that only the government can violate the constitutional guarantees to equal protection or privacy.[37] Individuals need not comply with these guarantees; freedom of association encompasses the right to choose one's friends on the basis of race or sexual orientation or whatever other yardstick one chooses to use.

Therefore, a state or federally run hospital or blood donation facility clearly would be governed by these constitutional commands; a purely private commercial facility probably would not be, although it could be held to be affected with a state interest.

What about a hospital or facility that, while privately owned and run, receives significant government assistance in the form of aid, tax exemptions, and other statutory benefits? The line between public and private action increasingly has become blurred in recent years as more and more ostensibly private agencies assume quasi-public characteristics or perform services for the government that it would otherwise have to perform for itself. Therefore, courts have adopted a doctrine known as "state action" to determine whether ostensibly private conduct has so implicated the agencies of the state that it is tantamount to unconstitutional state conduct. The Supreme Court has employed this analysis to bar courts from enforcing racially restrictive cove nants in real estate agreements[38] and to bar a municipa parking facility from leasing space to a restauranteur wh refused to serve blacks.[39,40]

The courts have retrenched somewhat in the last 15 years however, and have refused to classify government assistanc to a private party as "state action" unless that assistanc actually fosters or encourages the unconstitutional conduc This narrowing of "state action" was signalled by the Su preme Court's holding that furnishing a state liquor licens to a discriminatory private club was not state action. Becaus the state was a neutral which issued liquor licenses to dis criminatory and nondiscriminatory clubs alike, the cour concluded that issuance of a state liquor license did no encourage or foster the discrimination and refused to fin "state action."[41] Courts have since refused to find such actio unless the nexus between the government and the privat facility is so close that the actions of the latter may fairl be said to be the actions of the former. Such a nexus onl will be found where the government encourages or partici pates in the action, mere acquiescence is not enough.[42,4 Therefore, the Supreme Court refused to apply the "stat action" concept to a private nursing home despite the state' pervasive involvement in regulating and subsidizing th home as well as in adjusting the level of its Medicaid benefit in accordance with private decisions made by the employee of those facilities.[44] Similarly, numerous lower courts hav refused to apply the state action concept to hospitals,[45,46] an private outpatient facilities such as a kidney dialysis center.[4 We, therefore, think it unlikely that the actions of a bloo bank or a hospital would even amount to "state action" much less actually violate the Constitution.[48,49]

CONCLUSION

It is entirely possible that a duty could be imposed on blood donation facilities to prevent the spread of AIDS by asking questions to screen donors who are homosexual o Haitian, or who have a history of illicit drug use. Any fear of invading the rights of these donors to privacy or to equal protection does not appear to have a sound foundation in law. As weighty as these considerations might be, they almost certainly would be found to yield to the overwhelming community interest in preventing disease and contagion. Given the current state of the science, there does not appear to be any less restrictive a way of achieving this end. Moreover, it is questionable whether a private facility would be held liable for violating these rights even if it wished to.

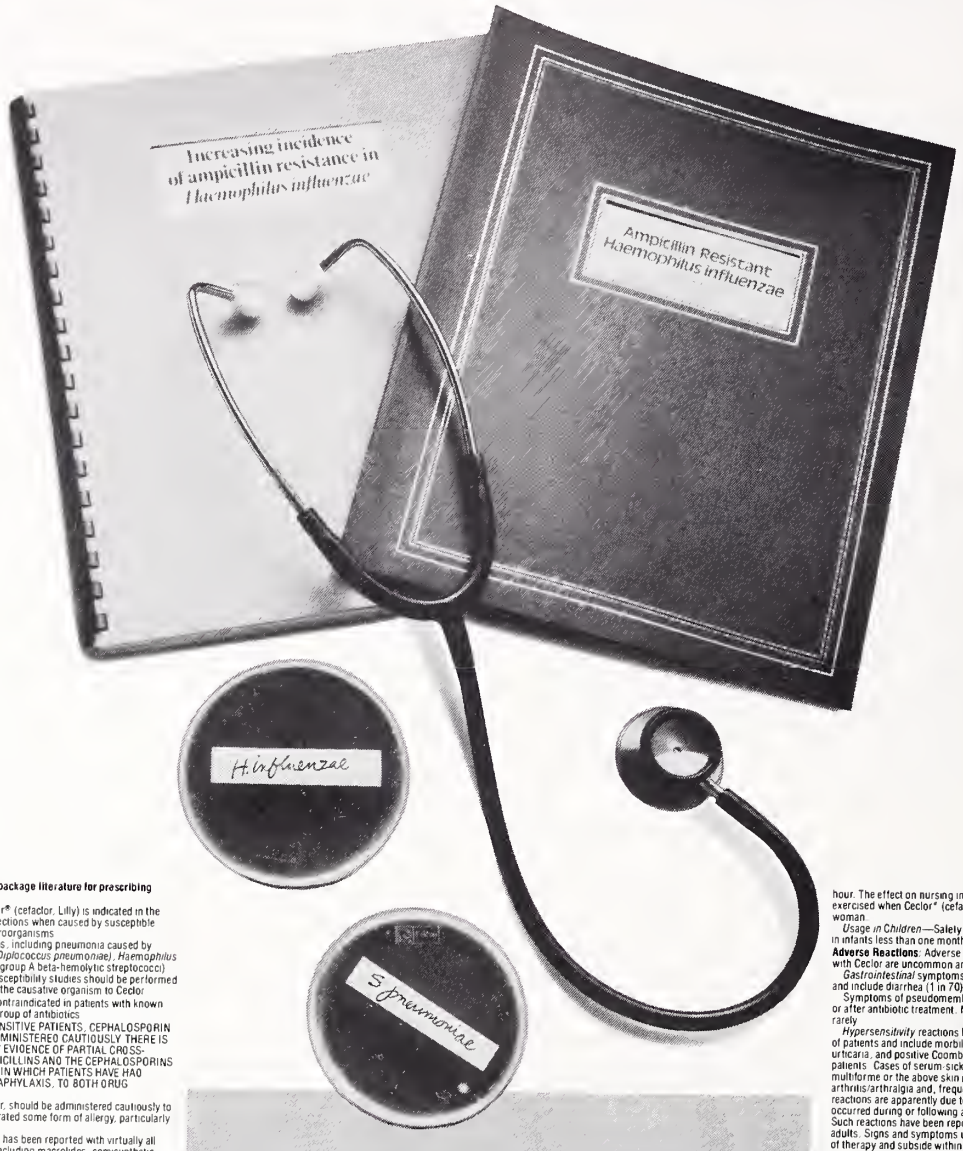
We note that no court has yet passed on this question. Any actual decisions would be made on a case-by-case approach on the basis of a full factual record. For that reason, this article is not intended to be definitive legal advice on the subject nor should it be so taken. Rather, this has simply been an opportunity for us to explore a current and controversial medical issue in the context of the common law and the Constitution.

REFERENCES

1. *Brody v Overlook Hospital,* 127 N.J. Super. 331 (App. Div. 1974), *aff'd* 66 N.J. 448 (1975).
2. *Schenck v United States,* 249 U.S. 47 (1919) (Oliver Wendell Holmes, J.).
3. 197 U.S. at 11 (1905).
4. 197 U.S. at 26.
5. 197 U.S. at 30-37.
6. 197 U.S. at 37-38.
7. *Mountain Lakes Board of Education v Maas,* 56 N.J. Super. 245,

)4-67 (App. Div. 1959) *aff'd,* 31 N.J. 537 (1960).
8. *Sadlock v Board of Education of Carlstadt,* 137 N.J.L. 85, 87-91 up. Ct. 1948).
9. *Davis v State,* MD, 451 A. 2d 107, 111-112 (Ct. App. 1982).
10. *McCartney v Austin,* 57 Misc. 2d 525, 293 N.Y.S. 2d 188 (Sup. t. 1968).
11. *Wright v Dewitt School Dist. 1,* 238 Ark. 906, 385 S.W. 2d 4 (Sup. Ct. 1965).
12. *Application of the President & Directors of Georgetown Colge,* 331 F. 2d 1000 (D.C. Cir.), *cert. denied,* 377 U.S. 978 (1964).
13. 197 U.S. at 38-39.
14. *Eisendstadt v Baird,* 405 U.S. 438 (1972); *Griswold v Connecti-t,* 381 U.S. 479 (1965).
15. *Roe v Wade,* 410 U.S. 113 (1973).
16. *In re Grady,* 85 N.J. 235 (1981).
17. *In re Quinlan,* 70 N.J. 10 (1976).
18. American Civil Liberties Union Handbook: *The Rights of Gay eople,* 1983 Appendix A at 131-166.
19. *New York v Onofre,* 424 N.Y.S. 2d 566 (N.Y. Sup. Ct. 1980).
20. *Beller v. Middendorf,* 632 F.2d 788 (9th Cir. 1980), *cert. denied* 30 U.S. 965 (1981).
21. *Ben Shalom v Sec'y of the Army,* 489 F. Supp. 964 (E.D. Wis. 980).
22. *McConnell v Anderson,* 451 F. 2d 193 (8th Cir. 1971), *cert. nied* 405 U.S. 1046 (1971).
23. *Gaylord v Tacoma School Dist. No. 10,* 88 Wash. 2d 286, 559 2d 1340 (1977), *cert. denied,* 434 U.S. 879 (1977).
24. Nemetz, 485 F. Supp. 470 (E.D. Va. 1980).
25. *Fricke v Lynch,* 491 F. Supp. 381 (D.R.I. 1980), *vacated and manded,* 627 F.2d 1088 (1st Cir. 1981).
26. *State v Saunders,* 75, N.J. 200 (1977).
27. *Southern Burlington County N.A.A.C.P. v Mount Laurel,* N.J. 983).
28. *In re Grady,* 85 N.J. 235 (1981) (state constitutional right of rivacy extends to the right to be sterilized); *State v Schmid,* 84 N.J. 35 (1980) appeal dismissed, 455 U.S. 100 (1982) (state constitutional right of free speech guarantees reasonable access to private university campus); *In re Quinlan,* 70 N.J. 10 (1976), *cert. denied,* 429 U.S. 922 (1976) (state constitutional right of privacy extends to the right of choice to terminate life support systems); *State v Johnson,* 68 N.J. 349 (1975) (state constitution may guarantee greater freedom from unreasonable searches and seizures than does the federal constitution).
29. *Roe v Wade, supra,* 410 U.S. at 163-64.
30. U.S. Const., Amend. 14 (applying to the states), Amend. 5 (applying to the federal government).
31. *San Antonio School Dist. v Rodriguez,* 411 U.S. 1, 40 (1973).
32. *Regents of the University of California v Bakke,* 438 U.S. 265, 306 (1978); *San Antonio School Dist. v Rodriguez, supra,* 411 U.S. at 16-17.
33. *Graham v Richardson,* 403 U.S. 365, 375-76 (1971).
34. *Craig v Boren,* 429 U.S. 190, 197-98 (1976), and might employ such an analysis if squarely confronted with a compelling case of discrimination based on sexual orientation.
35. *Beller v Middendorf, supra* note 18 at 808-09.
36. *Beller v Middendorf, supra,* 632 F.2d at 807-110; *DeSantis v Pacific Tel. & Tel. Co.,* 608 F. 2d 327 (9th Cir. 1979).
37. *San Antonio School Dist. v Rodriguez, supra,* 411 U.S. at 16-17; *Massachusetts Bd. of the Retirement v. Murgia,* 427 U.S 307, 312-13 (1976).
38. *Graham v Richardson, supra,* 403 U.S. at 375-76.
39. *Shelley v Kraemer,* 334 U.S. 1 (1948).
40. *Burton v Wilmington Parking Authority,* 365 U.S. 715 (1961).
41. *Marsh v. Alabama,* 326 U.S. 501 (1946).
42. *Moose Lodge No. 107 v Irvis,* 407 U.S. 163 (1972).
43. *Blum v Yaretsky,* U.S. 73 L.Ed 2d 534 (1982).
44. *Jackson v Metropolitan Edison Co.,* 419 U.S. 345 (1974).
45. *Blum v Yaretsky, supra.*
46. *See, e.g., Modaber v Culpeper Memorial Hospital, Inc.,* 674 F. 2d 1023 1026 n.10 (4th Cir. 1982).
47. *Newson v Vanderbilt University,* 653 F. 2d 110 (6th Cir. 1981).
48. *Greenspan v National Medical Care, Inc.,* 485 F. Supp. 311 (E.D. Va. 1980).
49. *State v Schmid, supra* note 20.

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor
Pulvules®, 250 and 500 mg

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor* (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.*
Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., *8*:91, 1975.
2. Antimicrob. Agents Chemother., *11*:470, 1977.
3. Antimicrob. Agents Chemother., *13*:584, 1978.
4. Antimicrob. Agents Chemother., *12*:490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II 880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., *13*:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

© 1982, ELI LILLY AND COMPANY

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

300035

CASE REPORTS

Hydatid Disease of the Liver

MICHAEL A. KESSLER, M.D., SIDNEY KETYER, M.D.,
JOHN V. CHOLANKERIL, M.D., JESUS CENIZAL, M.D., Elizabeth*

Chronic, recurrent upper abdominal pain in an individual from an area of the world endemic for echinococcosis disease should lead one to suspect hydatid disease of the liver. Two of three patients with characteristic ultrasound and computed tomographic features of this disease were proved to have *Echinococcus granulosus*. The morphologic findings may be specific, suggestive, or nonspecific but radiologic evaluation provides a strong diagnostic technique in such cases.

Hydatid disease involving the liver, due to *Echinococcus granulosus*, has become a relatively easy condition to demonstrate over the past several years utilizing ultrasound and computed tomography. Although the appearance not always is specific, sometimes the radiologic presentation permits a specific diagnosis to be made. Our experience with three patients stimulated a review of the literature.

CASE REPORT 1

A 46-year-old female, who came from Greece in the past year, was admitted to St. Elizabeth Hospital on December 15, 1976, with right upper quadrant abdominal pain. She gave a history of recurrent similar episodes over the previous two years, beginning while in Greece. The pain was associated with nausea and vomiting. The patient also reported recent fatty food intolerance.

Upon admission, physical examination revealed mild jaundice that developed over the previous two weeks. There was rebound tenderness in the right upper quadrant, but because of guarding, the liver was difficult to palpate.

Pertinent laboratory data included hemoglobin 11 gm; hematocrit 32; WBC 7,000. Total bilirubin was 6.4 mg/dl with direct of 4 mg/dl.

Ultrasound examination revealed a multiloculated cystic structure involving most of the liver (Figure 1). The common bile duct was not identified.

Surgery was performed and tissue was removed for pathological examination. Hydatid cystic disease secondary to *Echinococcus granulosus* was found. The biliary tract was described at surgery as completely obliterated by the pathology.

CASE REPORT 2

A 56-year-old male, a relative of our first patient, also originally came from Greece. He was admitted to St. Elizabeth Hospital on May 1, 1978, with upper abdominal discomfort and nausea and vomiting.

Pertinent physical findings consisted of epigastric tenderness, but no masses or organomegaly were noted. Ultrasound study of the abdomen showed a 9 cm cystic structure occupying the lower portion of the liver (Figure 2). There was a small daughter cyst noted within the larger cyst. Upon exploratory laparotomy and examination of aspirated fluid, echinococcal cyst *(Echinococcus granulosus)* was confirmed.

CASE REPORT 3

A 65-year-old male, born and raised in southern Italy, noted increasing abdominal girth over a three-year period. He denied pain or any other symptoms. Ultrasound and CT

*From the Department of Radiology, St. Elizabeth Hospital. Correspondence may be addressed to Dr. Kessler, St. Elizabeth Hospital, 225 Williamson Street, Elizabeth, NJ 07207.

examinations showed huge multiloculated cystic structures in the liver (Figures 3 and 4). Based on this appearance, echinococcal disease was suspected. However, the patient refused any further studies or treatment, and the diagnosis never was proved. This case is included because the ultrasound and CT features are identical to cases of echinococcal liver involvement found in the radiological literature.[4,8]

DISCUSSION

In the United States, one is not likely to consider echinococcosis disease despite a clinical presentation consistent with it. However, particularly with world travel and migration, the epidemiological patterns have shown change.[4] Echinococcal disease often causes upper abdominal pain that may be recurrent and chronic. Such a clinical presentation often will prompt the physician to request an abdominal ultrasound examination. One may consider the diagnosis when simple or more complex cystic structures are found in the liver. If the patient has spent time in one of the endemic areas, the diagnosis can be considered with more confidence. Our first two patients originally came from Greece and were members of the same family. Our third patient came from Italy which also is an endemic area for the disease.

Hydatid (a drop of water) disease may be caused by either one of two species of tapeworm.[10] Most commonly, the organism is *Echinococcus granulosus,* which is endemic in South America, the Near and Middle East, North Africa, Australia, New Zealand, and southern Europe. The less common organism, *Echinococcus alveolaris* most commonly is seen in central Europe, Russia, Alaska, Japan, and the United States.[1,2,3,6]

The life cycle of *E. granulosus* has been well described.[1,4,5,11] The primary host is the dog, which harbors the adult form in the small bowel villi. Eggs in the dog's feces are ingested by the intermediate host, usually sheep and cattle, but occasionally man. Areas of cattle and sheep raising therefore are sites that will be endemic. The eggs hatch in duodenum and liberate oncospheres; these migrate to the liver via the portal circulation, where, for the most part, they are filtered. A second filter is the pulmonary circulation.[5] Beyond this, a small percentage gets to the brain, kidneys, and bone.

RADIOLOGIC FINDINGS

In the liver, hydatid disease secondary to *E. granulosus* can show several different echogenic patterns. Hadidi described a classification of four different patterns: solitary cysts; large cyst with one or more smaller daughter cysts within it; multiloculated cyst; and multiple cysts.[7] If internal echoes are present in these cystic structures, such presentation could signify suppuration, with secondary infection of the cysts.

Gharbi et al. described the findings of 121 patients in Tunisia and presented a similar, although more complex classification.[6]

The finding in our case 1 was a solitary cyst; the liver in case 2 revealed a daughter cyst within a larger cyst; and case 3 showed a septated multiloculated cystic structure shown on both ultrasound and computed tomography. The solitary cyst is not ultrasonographically specific, since simple cysts, abscess, hematoma, and metastasis can give this appearance. The presence of a daughter cyst, however, is quite specific for hydatid disease.[7] The multiloculated cyst appearance also can be the result of a tumor, such as a hepatic cystadenoma; the multiple cysts would have a nonspecific appearance.

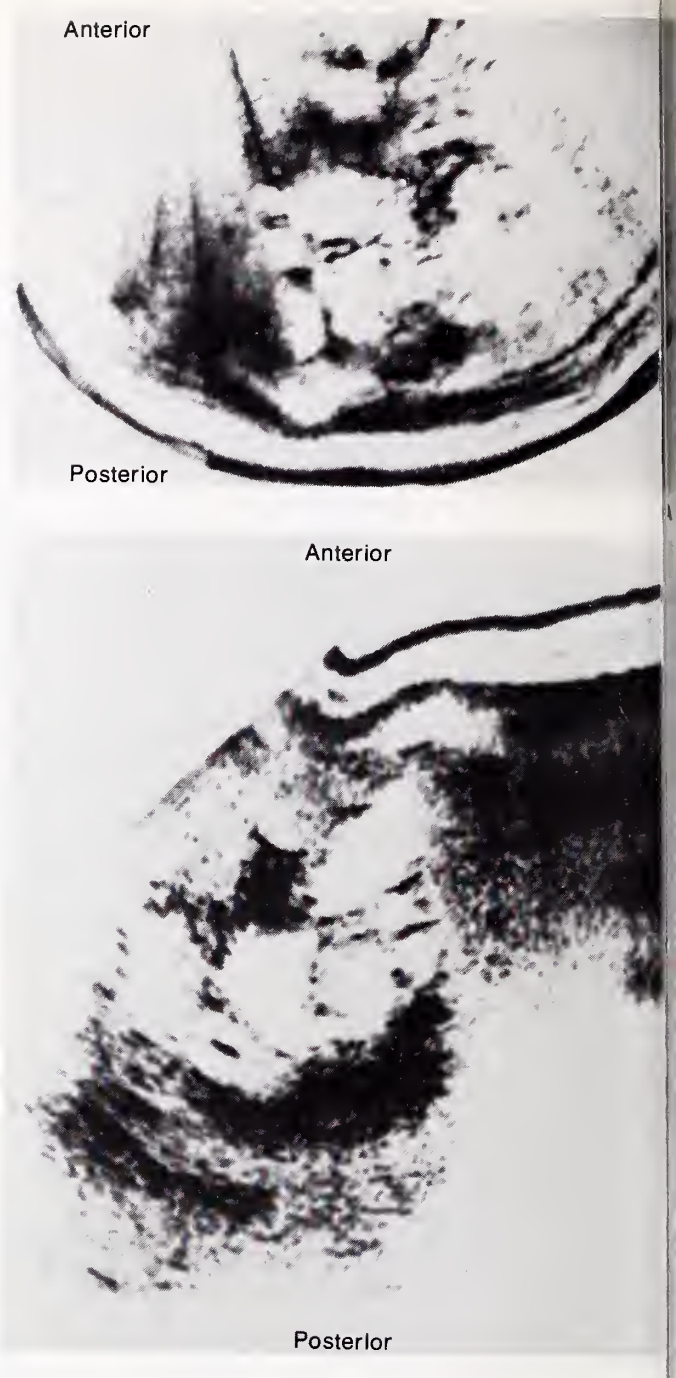


Figure 1—Transverse ultrasound image showing multiloculat cystic structure involving most of the liver **(A)** and longitudir scan 2 cm to the left of the midline **(B)** in patient 1.

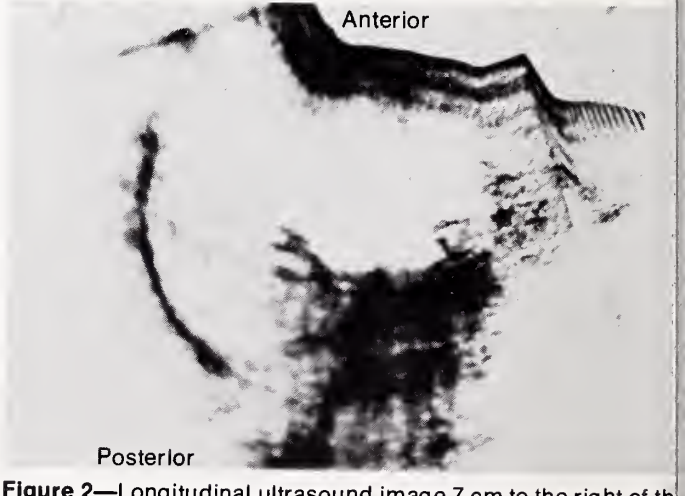


Figure 2—Longitudinal ultrasound image 7 cm to the right of th midline showing large cyst in lower part of right lobe of liver i patient 2. Small daughter cyst is present. This appearance virtually diagnostic for echinococcosis.

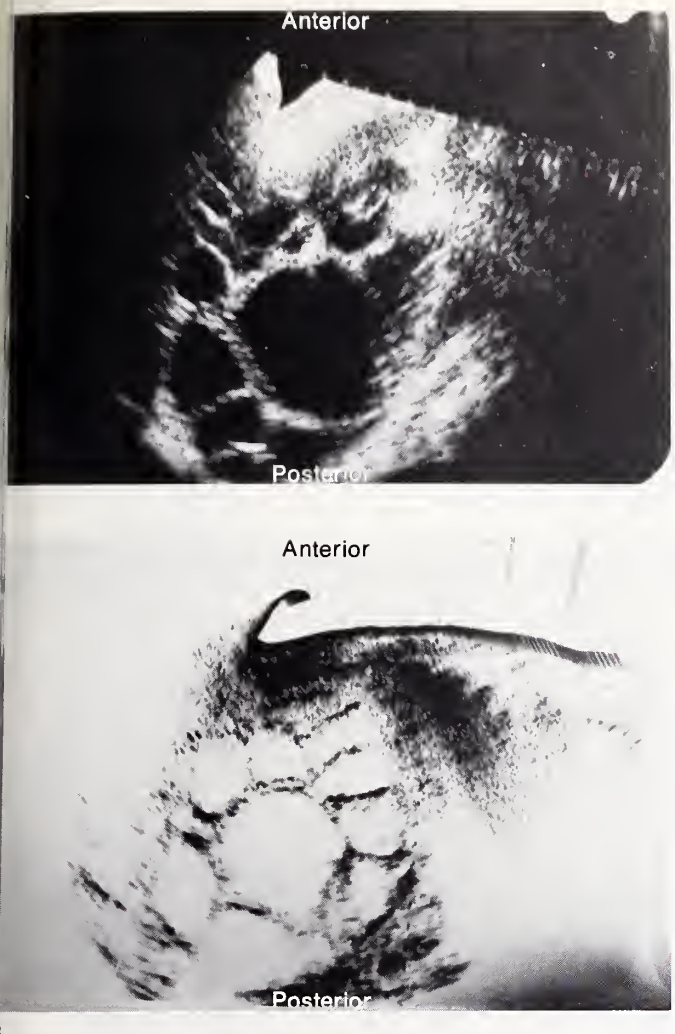


Figure 3—Transverse ultrasonogram showing multiloculated cystic structure in liver in patient 1 **(A).** Longitudinal sonogram of same patient, slightly to the right of the midline **(B).**

The computed tomographic (CT) findings in *E. granulosus* involvement of the liver also are described in the literature.[4,9] The cystic structures are well defined and contain fluid-filled interiors with densities between 3 and 30 Hounsfield (HU) units. The same types of patterns as seen on ultrasound are found.

E. alveolaris, which is seen less often then *E. granulosus,* is described by Scherer et al. as showing, on CT scan, a low density (14 to 38 HU) irregular mass lesion in the liver with no visible surrounding membrane.[9] It will resemble an invasive tumor and the correct diagnosis cannot be made radiographically.

SUMMARY

Three patients have been described, the first two of whom were documented by surgery and pathological examination to have hydatid disease of the liver. The first patient's ultrasound examination was suggestive of echinococcosis with multiloculated cystic structures. The second patient showed a daughter cyst making the appearance virtually specific. The third patient showed another striking multiseptated cystic structure on ultrasound and CT examinations that was identical to that in other cases of echinococcosis presented in the literature.



Figure 4—Computed tomography image 8 cm below the xiphoid shows multiloculated cystic structure in liver in patient 3. The fluid in the cyst was approximately water density and did not enhance following contrast. The morphology is similar to that demonstrated by ultrasound in Figure 3A, which was in a similar orientation.

REFERENCES

1. Alltree M: Scanning in hydatid disease. *Clin Radiol* 30:691-697, 1979.

2. Babcock O, Kaufman L, Codnow I: Ultrasound diagnosis of hydatid (echinococcosis) in two cases. *Am J Roentgenol* 131:895-897, 1978.

3. Biggi E, Derchi L, Cicio G R, Valente M: Sonographic findings of hydatid cyst of the liver ruptured into the biliary ducts. *J Clin Ultrasound* 7:381-382, 1979.

4. Choliz JD, Lecumbern Oloverri FJ, Franquet Casas T, Ostiz Zubieta S: Computed tomography in hepatic echinococcosis. *AJR* 139:699-702, 1982.

5. Gonzalez LR, Marcos J, Illanas M, Hernandez-Mosa M, et al.: Radiologic aspects of hepatic echinococcosis. *Radiology* 130:20-27, 1979.

6. Gharbi HA, Hassine W, Brauner, MW, Dupach K: Ultrasound examination of the hydatic liver. *Radiology* 139:459-463, 1981.

7. Hadidi A: Ultrasound findings in liver hydatid cysts. *J Clin Ultrasound* 7:365-368, 1979.

8. Kirschner LP, Ferns RA, Mero JH, Moss ML: Hydatid disease of the liver evaluated by computed tomography. *J Comput Tomogr* 2:229-236, 1978.

9. Scherer U, Weinziel M, Sturm R, Schildberg FW: Computed tomography in hydatid disease of the liver: A report on 13 cases. *J Comput Assist Tomogr* 2:612-617, 1978.

10. *Steadman's Medical Dictionary.* Baltimore, MD, Williams & Wilkins Co., 1966, p. 753.

11. Weirch WL: Hydatid disease of the liver. *Am J Surg* 138:805-808, 1979.



When it comes to saving lives, teamwork becomes not only desirable; it becomes necessary.

In an operating room, in an emergency room, in consultation with other physicians, teamwork helps you do your job to the best of your ability.

The American Medical Association and your state and county medical societies believe in the value of teamwork — and the necessity of it, in the face of an increasingly complex professional environment.

We also believe that medical societies have certain tasks that the individual physician couldn't possibly assume — and shouldn't have to.

For example, to keep government regulations from interfering with your practice, we effectively represent your interests at local and national levels.

To influence policies of organized medicine with which you disagree, we provide the means to have your views heard and respected.

And to keep you up to date on the latest medical advances, we publish JAMA, AM News, specialty, state, and county journals.

In fact, for all the times you can't operate alone, your medical societies will be there. Working with you to defend your rights and protect your freedoms.

Join Your Medical Societies Today.

For more information, contact your county or state medical societies, or call the AMA collect at 312/751-6196. Or return the coupon below to your state or county medical society.

☐ Please send me information on AMA, county, and state society membership.

☐ I am a member of my county and state societies; please send me information on joining the AMA.

Name _____

Street _____

City _____ State _____ Zip _____

County _____

Fine-Needle Aspiration in Metastatic Malignant Melanoma

DONALD ROTHMAN, M.D., YAYONE OLAIZOLA, M.D.,
JOHN BAKER, C.T., Red Bank*

Nine patients in the past three years had percutaneous fine-needle aspiration of metastatic subcutaneous nodules and masses using a quick stain of air-dried material. The results led to more prompt surgical treatment and established proof of metastases, and made the diagnosis in two cases with occult primaries.

Fine-needle aspiration (FINA) of various lesions (breast, thyroid, lung, pancreas, and brain) is gaining wider popularity. We will discuss the usefulness of FINA of nodules in melanoma patients since clinical information about secondary lesions often determines the prognosis and role of further surgery. Palpation alone notoriously is inaccurate. Therefore, cytology of readily accessible masses would appear a rapid, simple way to establish proof of metastatic disease. Recent experience with a variety of cases prompted this report (Table).

METHODS

A 1½-inch, 22-gauge needle on a 20 cc plastic syringe in a special syringe holder is thrust into the lesion, which is held in place by the fingers. The needle is moved up and down in the mass numerous times with 10 cc of suction applied. Cytological material is fractured off by the needle cutting edge and aspirated into the needle (not the syringe); the suction is released and allowed to equilibrate while the needle still is in the tissue. After withdrawal, the needle is removed, air introduced into the syringe, and the needle replaced. The specimen from the needle is blown onto a slide, smeared, and air-dried. Diff-quik stain is used. After drying and coverslipping, cytological review is made. Characteristic malignant melanocytes and some with pigment can be appreciated.

CASE REPORTS

A 50-year-old man developed a 2 cm right axillary recurrence proved by needle biopsy. One year earlier he had bilateral axillary lymphadenectomy for chest wall melanoma at Sloan-Kettering Memorial Hospital, New York. The patient promptly returned to his original surgeon for more radical treatment.

A 57-year-old woman had a malignant mole excised 20 years earlier from the right forearm and skin grafting. She presented with a 10 cm fixed axillary mass, proved to be metastatic melanoma upon aspiration biopsy. The lesion was unresectable.

A 55-year-old man proved to have recurrent metastatic melanoma with a fine-needle aspiration biopsy of an abdominal wall lesion (Figure 1). He did not respond to dacarbazine (DTIC) or radiation.

A 55-year-old man with an infected superficial spreading melanoma of the nipple was treated with wide excision after being treated for dermatitis of the breast for two to three months. A left axillary node aspiration indicated lymphadenitis and subsequently this has subsided under observation.

*From the Departments of Surgery and Pathology, Riverview Hospital, Red Bank. Correspondence may be addressed to Dr. Rothman, 565 Highway 35, Red Bank, NJ 07701.

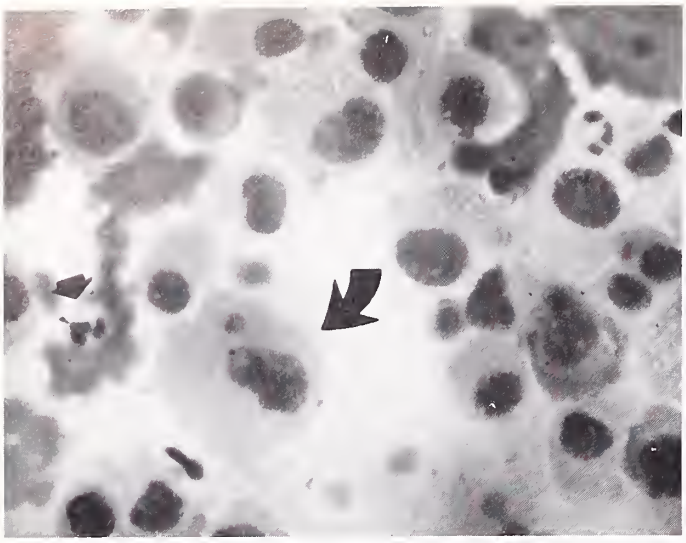


Figure 1—Large irregular cells with dark irregular nuclei and abundant cytoplasm (large arrow) are many times the size of polymorphs (small arrow) (diff-quik stain at 400 power).

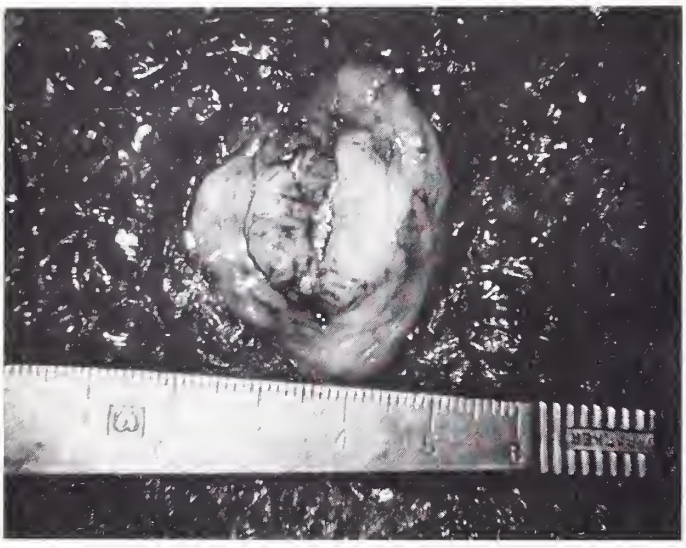


Figure 2—Lymph node metastasis.

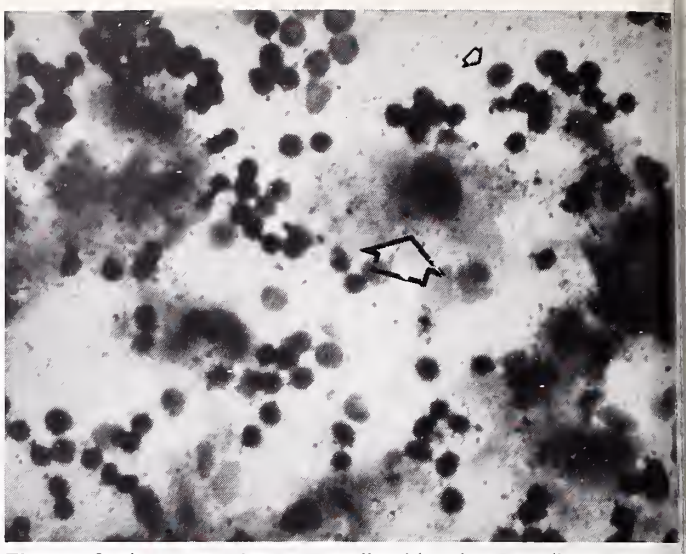


Figure 3—Large melanoma cell with pigment (large arrow many times the size of RBC (small arrow) (diff-quik stain at 400 power).

A 75-year-old man presented with a small cutaneous lesion of the back and a large axillary mass. Aspiration of the mass indicated metastatic neoplasm. Subsequently, an excision of the primary melanoma of the back and lymphadenectomy were carried out.

A 44-year-old man presented with a melanoma of the back which was widely excised and skin grafted. Several months later, a node in the axilla was aspirated and found to have metastatic melanoma; he underwent a node dissection (Figure 2).

A 30-year-old man underwent wide excision of a melanoma of the left shoulder. Three months later, a left axillary node yielded positive cells and an axillary dissection was carried out.

A 27-year-old woman presented with a subcutaneous nodule of the right neck. Fine-needle aspiration yielded heavily pigmented melanoma cells (Figure 3) with no primary site. A radical neck dissection was promptly carried

TABLE

Recent Experience

Age	Sex	Presentation	Aspirate	Treatment	Followup
50	M	Recurrent mass in axilla	Positive	Further surgery	Expired
57	F	Recurrence in axilla	Positive	None	Expired
55	M	Recurrence in abdominal wall	Positive	None	Expired
55	M	Superficial melanoma of breast—with axillary node	Negative	None	Node receded
75	M	Skin lesion and axillary mass	Positive	Wide excision lymphadenectomy	Expired
44	M	Axillary recurrence	Positive	Axillary node dissection	Subsequent recurrences
30	M	Axillary recurrence	Positive	Axillary node dissection	No evidence of disease (6 months)
27	F	Neck nodules, unknown primary	Positive	Neck dissection	No evidence of disease (6 months)
57	M	Groin node, unknown primary	Positive	Groin dissection	No evidence of disease (1 year)

ıt at Sloan-Kettering Memorial Hospital.

A 57-year-old man developed a mass in the groin. Fine-edle aspiration yielded melanoma cells in a lymph node; primary was found. He subsequently underwent radical oin dissection at the University of Pennsylvania Hospital.

ISCUSSION

Fine-needle aspiration of various organs has proved merit. ytology of melanoma nodules is reported in the literature, ıt is not practiced widely.[1] There now are reports of tological diagnosis of the primary skin lesion as well.[2,3] ecurrent melanoma in subcutaneous nodules and nodes ften poses no problem to the cytopathologist. The large alignant cells and pigment can be seen. Complications are w with fine-needle aspiration biopsy and metastatic seeding as been shown to be virtually nil. In these nine cases (Table), needle aspiration established a rapid diagnosis which helped in decision making. Several biopsies led directly to more radical surgery—a few negated the need for open surgical biopsy, and in two with occult primaries, the pathology was suggested prior to histological sectioning. Therefore, fine-needle aspiration biopsy is a useful tool in patients with metastatic malignant melanoma.

REFERENCES

1. Hafström L, Hugander A, Jönsson P, et al.: Fine-needle aspiration cytodiagnosis of recurrent malignant melanoma. *J Surg Oncol* 15:229-234, 1980.
2. Woyke S, Domagala W, Czerniak B, et al.: Fine-needle aspiration cytology of malignant melanoma of the skin. *Acta Cytol* 24:529-538, 1980.
3. Fontanière B, Noël P, Mayer M, et al.: The place of cytodiagnosis in black tumors of the skin: Its value and limits. *Pigment Cell Basel, Karger* 2:239-245, 1976.

The Art of Banting

ARTHUR KROSNICK, M.D., Lawrenceville*

Sir Frederick G. Banting, Nobel Laureate for the discovery of insulin, was also an amateur artist, an art collector, and a friend and admirer of Canadian artists. An original watercolor sketch on the cover of this issue provides a perfect reason to discuss the art of Banting.

Our cover is a publication first—it represents an unpublished original painting by Sir Frederick Banting, codiscoverer of insulin and a 1923 Nobel Prize recipient. The watercolor sketch is owned by Sylvia Swern, the widow of Dr. Nathan Swern, a New Jersey diabetologist, who died July 27, 1958.

"Banting dabbled in paints at an early age and made creditable pictures as a schoolboy. Then he busied himself with other things and the talent was apparently buried and forgotten. During the rueful year in London [Ontario] he resumed his boyhood's hobby and improved the long intervals of waiting with fresh excursions into the delectable realms of art. He battled ennui with palette and brush. He forgot his dashed hopes and his hobbling practice as he squeezed blobs of colour from his paint-tubes."[1]

This description refers to the period between completion of his training as an orthopedic surgeon when he was trying to establish a practice and his research into the elusive pancreatic hormone. Paintbrushes once more were taken out: "Banting once slipped away from a medical convention in Montreal and escaped to the mountain for a half a day of indulgence in the quiet luxury of painting; this was not an isolated instance of his guilty truancy."[2]

Banting's debut as an artist occurred in January 1925 when two of his oil paintings were displayed in the Hart House Sketch Club exhibition. His friend and mentor was A.Y. Jackson, a Canadian artist and founder of the "group of Seven," with whom Banting had a "most enthusiastic and lasting attachment." This group of professional artists became his intimate friends. Jackson said: "He knew many of the artists. He was very welcome in art circles. He became a very popular member of the Arts and Letters Club and was a good friend to the young people in the Art Students' League. He was generous in his admiration and never allowed his eminence in science to give weight to his opinions of questions of art."[1]

Landscape with figures was the subject which interested Banting the artist most.[1] Jackson and Banting made numerous sketching expeditions together, the first of which was to St. Jean Port Joli on the south shore of the St. Lawrence in March 1927. Jackson was not unamused by the reactions of his protégé: "There was no sign of spring. It was cold and windy and very exposed country. We would crouch behind barns and rail fences to sketch. He was almost frozen stiff every day, but he struggled with frozen paint and fingers. His only comment on one bitterly cold day was, 'And I thought this was a sissy game.' "[1]

The subject of our cover picture appears to be St. Irenée in Quebec; it was probably painted in 1930 or 1931.[4] A painting similar to the Swern watercolor was owned by C.A.G. Mathews and was listed as item 51 in a catalogue of an exhibition entitled, "Banting as an Artist," a collection of sketches by Sir Frederick Banting (1891-1941) at the Academy of Medicine, Toronto, October 21-30, 1971.

*Dr. Krosnick is a diabetologist and Editor, *The Journal,* MSNJ. Correspondence may be addressed to Dr. Krosnick, MSNJ, Two Princess Road, Lawrenceville, NJ 08648.

How did Nathan Swern acquire the painting which rests comfortably on the wall of Mrs. Swern's apartment in Trenton? Dr. Swern graduated from New York University and then from Jefferson Medical College in 1922. He was a Diplomate of the American Board of Internal Medicine, a Fellow of the American College of Physicians, President of the Mercer County Medical Society, Chairman of the Mercer County Diabetes Detection Committee, and member of the Board of Governors of the New Jersey Diabetes Detection Committee and of the American Diabetes Association.

Dr. Swern met Dr. Banting at a diabetes meeting in New York between 1931 and the onset of World War II. (Banting died in a plane crash in Newfoundland enroute to England on February 20, 1941.) Banting had spoken of the French statesman Georges Clemenceau as having lived to age 88 with diabetes, which purportedly made him the oldest living diabetic until his death in 1929. Banting wanted to learn of other such elderly diabetics and was very pleased to hear from Dr. Swern of a patient of his, a Mr. Bonner from Trenton, who was over 90 years of age. Swern and Banting apparently saw each other on occasions and, as a gesture of friendship, Banting gave the sketch to Dr. Swern:[2] "He did exhibit in some of the exhibitions but was always afraid that he got in on account of his reputation as a scientist rather than as a painter, so after a while he stopped sending. His paintings are scattered all over the place. To anybody who admired one of his paintings he would say, 'Oh, well, you can have it.' " [3]

On February 21, 1943, the second anniversary of the death of Sir Frederick was memorialized by an exhibition of his paintings, drawings, and wood carvings at the Art Gallery of Hart House at the University of Toronto. The exhibition contained all of the paintings by Banting which were known to exist: "An attempt was made to discover every piece of Sir Fredericks' artwork in Canada, the United States, Great Britain, or elsewhere, and to include it in the list at the end of this book. If some have been missed, it is hoped that owners will communicate with the warden of Hart House in order that the record may be as complete as possible."[4]

Obviously, the Swern watercolor sketch was not reported, but it has provided the impetus to describe and discuss the art of Sir Frederick Banting. This side of the great scientist was unknown to most of his admirers and to the current generation of American physicians. Talent comes in clusters and this Nobel Laureate left the world a legacy from his scientific and artistic gifts of God.

REFERENCES

1. Stevenson L: *Sir Frederick Banting.* Toronto, Canada, The Ryerson Press, 1946, pp. 231-239.
2. Swern S: Personal communication, 1983.
3. Jackson AY: Memories of a fellow artist. Frederick Grant Banting. *Canad Med Assoc* 92: 1077-1082, 1965.
4. Jackson AY: *Banting as an Artist.* Toronto, The Ryerson Press, 1943.

Advocacy

DAVID I. CANAVAN, M.D., Lawrenceville*

The final phase of our program for the rehabilitation of our impaired colleagues requires the commitment of a significant amount of time, effort, and ingenuity. Returning our recovering physician clients to their rightful place in the medical fraternity is no small task.

In my travels around the state I have encountered three common myths about physicians:

Myth 1: Physicians are exempt from the diseases that we consider "impairment."

Myth 2: If the physician, in contradiction to myth 1, does acquire one of these diseases, the therapeutic process is not expected to work.

Myth 3: If the physician, in contradiction to myth 2, manages to succeed with the therapeutic process, that physician is not entitled to return to the ranks of the profession.

In support of myth 3, there are several attitudes that prevail around the state.

The first attitude is that physicians who fall victim to these diseases have become professional "outcasts," "moral lepers," or "untouchables." They often are looked upon as a disgrace to the profession rather than as human beings who happen to be physicians and who are the victims of diseases that they never wanted in the first place.

The next attitude is seen more commonly in our dealings with hospital administration. Here the concern has to do with the "public image" of the institution that permits a doctor with a history of impairment to return to its staff.

The third attitude that also is prevalent suggests that the impaired physician who is recovering should prove himself at another institution and after succeeding there then may be worthy of consideration at the original hospital.

In my 28 years in the field of alcoholism and drug abuse, I constantly have been amazed by my "recovering" patients. The substance abusers that I have treated are some of the finest people I know. I used to think that the Creator, in a spirit of justice, had endowed these folks with some special qualities to make up for the fact that they had been awarded a disease that they did not want. As my experience increased, I came to realize that these were simply fine people to start with. When their disease was controlled, the qualities and talents that always were there began to reappear.

The same experience is there with our recovering physicia clients and I can testify that these doctors are by no mea second-class persons or physicians.

The attitude of hospital administration about the "publ image" of the hospital being tarnished by accepting an a propriately treated physician back to its staff is a contradi tion to the entire mission of the hospital to restore patien to health. How do we preach the doctrine of recove through appropriate treatment and deny the product of a propriate therapy the right to return to the staff? Hospita can and should be criticized for denying the existence c "impairment" in their staff and for failing to take a propriate action when it exists. No one can justly criticiz a hospital that restores an appropriately treated physicia to his rightful place on the staff. It seems to me that th "public image" of the hospital is more in the eyes of th administrators than in the eyes of the community. As far a the third attitude is concerned, there is no "St. Elsewhere's in the real world. If an impaired physician is to be returne to the ranks of the profession, the ideal place is at th institution where the "fall from grace" occurred. There ma be occasional exceptions to this general rule. However, th attitude that it is someone else's responsibility to assist i this phase totally is unacceptable.

In the role of "advocate" for program clients, we finc ourselves in many different arenas.

1. The State Board of Medical Examiners. The Impaire Physicians Program enjoys an excellent relationship with th State Board of Medical Examiners (SBME). Our good rela tionship is based on mutual trust and a reputation for integri ty. We recognize the legal and moral responsibilities of th SBME to protect the public welfare and the SBME rec ognizes our concern for therapeutic intervention in the legit imate illnesses of our clients. These two positions not alway are in conflict, and experience has shown that when both of us work together, in harmony, we can both achieve our individual goals quite comfortably.

Our role here is to assist the SBME in delineating the

*Dr. Canavan is Medical Director, Impaired Physicans Program. Correspondence may be addressed to Dr. Canavan, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648.

ysician's impairment, and assessing the part that it may ve played in the problems that have brought the physician fore the SBME. It is important that we document the erapeutic measures that have been employed to treat the ecific impairment, and also to present whatever evidence available to demonstrate the continuing participation of e physician in our ongoing therapeutic and monitoring deavors.

On several occasions we have been able to submit a treatent/rehabilitation/followup proposal to the SBME for oning management of a particular problem that has been cepted and implemented in its entirety.

2. The Malpractice Insurance Companies. Because of the ose liaison that our program has with the malpractice rriers who generously provide two-thirds of our operating idget, we have been able to defend effectively the right of me of our clients to have their malpractice coverage conued or restored. We also are able to provide ongoing ocumentation of recovery when that information is necesry to continue coverage.

3. Hospital Credentials Committees. Physicians who are e victims of one of the diseases of impairment often run to difficulty with credentials committees. It is an important rt of the task of the medical director to appear before such mmittees to educate the committee about the nature of the npairment, its identification, its appropriate and effective eatment, and of the rights of the recovering physcian to be returned to an appropriate level of staff priviges.

We are in a position to advise the committee concerning ppropriate safeguards that may be built into the appointent or reappointment agreement that will provide protecon to hospital patients in the event of further impairment. s an example there are specific measures in the area of urine nonitoring that virtually can assure that a recovering drug-abusing physician cannot return to his drug abuse without prompt detection at the hospital.

4. Hospital Boards of Trustees. Most often our role here involves education of the trustees about appropriate treatment for the impaired physician and the program of the Medical Society of New Jersey for the ongoing supervision of their rehabilitation. Once again, we can assist the hospital board in exercising their stewardship by developing protocols for the appropriate documentation of the physician's continuing treatment and recovery.

5. Employment. One of the most difficult areas of our involvement is in the effort to assist our clients in finding appropriate employment in the field of medicine so as to return their own self-esteem and at the same time to satisfy the limitations of the SBME. There is nothing more frustrating than to see a perfectly capable physician, effectively treated for his illness, who remains idle at home because he cannot find employment either because of the restrictions on his license or the unwillingness of medical employers to take a chance on a "dark horse."

6. Economic Issues. While this is not a routine area of our involvement, there is an occasional case in which advocacy involves assisting a recovering physician in doing a realistic analysis of his current economic situation and working out an effective economic strategy to survive a period of impaired income.

There are other more subtle and less formal ways in which we "go to bat" for our clients in their uphill battle to regain good health, equanimity, community and professional acceptance and, above all, self-respect.

This article concludes the series on the Impaired Physicians Program. Future articles will deal with a review of the current "state of the art" in some of the specific impairments; policy issues and dealing with impairment; and a review of specific problem cases of an educational interest.

AN ACT OF LOVE

Their own **DENIAL** that a respected colleague could be **IMPAIRED** and/or the "conspiracy of silence" that makes them unwilling to speak out allows the illness of our impaired colleagues to progress, sometimes to a fatal outcome.

"Blowing the whistle" on a suffering colleague is indeed an **ACT OF LOVE!**

Call Us **EARLY**
We can help **CONFIDENTIALLY**
IMPAIRED PHYSICIANS PROGRAM
(609) 896-1766
Hot Line . . . (609) 896-1884

Housing Application

218th ANNUAL MEETING
THE MEDICAL SOCIETY OF NEW JERSEY

MAY 3-6, 1984

	Single	Twin	Suites
Resorts International (headquarters hotel)	$80.00	$80.00	$171/$250
Harrah's Marina Hotel Casino	$75.00	$75.00	
World International Hotel/Motel	$58.00	$58.00	
Lafayette Motor Inn	$58.00	$58.00	

Rates subject to 12% state and local taxes; tax subject to change.

All hotel reservations for the 218th Annual Meeting of MSNJ will be handled by the Atlantic City Convention Bureau. Please send your housing application with your 1st. 2nd, and 3rd choices directly to the Bureau, 16 Central Pier, Atlantic City, NJ 08401. All Delegates and Members are urged to make their hotel reservations early. Blocks of rooms will be available at Resorts International (headquarters hotel), Lafayette Motor Inn, World International Hotel/Motel, and Harrah's Marina Hotel Casino. The cut-off date for reservations will be April 6, 1984. Reservations cannot be guaranteed after this date. No Saturday arrivals please. All registrants will be charged for three nights: Thursday, Friday, and Saturday, May 3, 4, and 5, 1984.

MAIL THIS APPLICATION DIRECTLY TO THE ATLANTIC CITY CONVENTION BUREAU
16 Central Pier
Atlantic City, NJ 08401

Please list 1st, 2nd, and 3rd choices; confirmation will come directly from hotel.

1st Choice _____ 2nd Choice _____

3rd Choice _____

Accommodations desired: ☐ Single ☐ Twin ☐ Suite Parlor & 1 Bedroom
☐ Suite Parlor & 2 Bedrooms

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

Will arrive _____ (date) Time _____ Will depart _____ (date) Time _____

☐ Check if Official Delegate _____ County _____

rustees' Minutes ecember 18, 1983

A regular meeting of the Board of ustees was held on December 18, 83, at the Executive Offices in Lawnceville. Detailed minutes are on file th the secretary of your county medil society. A summary of significant tions follows:

eport of the President . . .
) Meeting with State Commissioner of ealth . . . Received a report from the cond meeting of representatives of ISNJ with J. Richard Goldstein, M.D. irected that the appropriate protocol e developed for use by the Department f Health in continuing the study of the admission rate experienced through arly discharge of patients under the RG method of reimbursement.

?) 1985 Annual Meeting . . . Approved ie following recommendation:

That the 1985 Annual Meeting of the Medical Society of New Jersey be held at the Americana Host Farm Resort and Conference Center in Lancaster, Pennsylvania.

Report of the Executive Director . . .
1) Paid 1983 Membership . . . Noted hat paid membership as of November 0, 1983, was 7,506.
2) Financial Statements . . . Approved he financial statements for the period nding November 30, 1983.
3) State Board of Medical Examiners SBME) Proposed Rule on Laetrile . . . Directed that the SBME be urged to join vith MSNJ and prohibit the use of aetrile in New Jersey.
4) Fee for Service—Pathology/TEFRA Regulations . . . Agreed to adopt the position that the signature of hospital-based physicians must be required on any form which includes either monetary values or distribution formulas of Part A and Part B components before the form is filed with governmental agencies, intermediaries, carriers (or any others to whom the form is sent), and that appropriate bilateral discussions and agreements should be reached before the form is signed.
(5) Blue Ribbon Ad Hoc Health Care Facility Committee . . . Noted that the Ad Hoc Committee voted six to two to include physicians in the certificate of need process for equipment expenditures exceeding $400,000. Noted that legislation will be required to effect the inclusion of a physician's private practice under the certificate of need requirement and MSNJ will be informed of all developments in this regard.

Academy of Medicine of New Jersey (AMNJ) . . . Received as informative the written monthly report from Paul J. Hirsch, M.D., President of AMNJ (see page 145).

Committee on Medical Education . . .
Workshop on Surveying Techniques . . . Approved the following recommendation:

That the Medical Society of New Jersey consponsors with the Academy of Medicine of New Jersey a surveying techniques workshop for directors of medical education and other personnel in New Jersey hospitals involved in continuing medical education.

Special Committee on Long-Range Planning and Development . . .
(1) Direct Candidacy for Elective Office—Substitute Resolution #5 . . . Referred back to the Committee for rewording and itemization the following recommendation:

That the Nominating Committee, with input from the Board of Trustees, develops a slate of two or three candidates for the positions of President-Elect, First and Second Vice-Presidents, Secretary, Treasurer, and Judicial Councilors. (Trustee positions were deleted because of a subsequent recommendation made by the Committee.

(2) Dues Discount for Medical School Faculty with Less than Six Years of Service . . . Disapproved the following recommendation:

That full-time faculty members, with less than six years of service, be granted a 25 percent discount until they achieve six years of service at the University of Medicine and Dentistry of New Jersey. The discount would not apply to department chairmen, assistant deans, or other senior positions within the administration and faculty.

(3) Composition of the Board of Trustees . . . Disapproved the following recommendation after much discussion:

That the present election process of the Board of Trustees by the House of Delegates be changed and that each county medical society have the responsibilty to elect or appoint one Trustee, with the provision that any county with more than 750 active members shall be entitled to an additional Trustee, with a limitation of two Trustees from any given county. (If approved by the Board of Trustees, the recommendation should be forwarded to the Committee on Revision of Constitution and Bylaws for development of an amendment to the Bylaws.)

(4) Demographic Study of Membership . . . Approved the following recommendation:

That the Board of Trustees contacts the New Jersey specialty society groups involved (family practice, pathology, psychiatry, anesthesiology, and general surgery), and the New Jersey medical schools, for comment and suggestions with regard to the possible need for physicians in these areas as shown by the statewide age study.

(5) Review of MSNJ's Committee Structure . . . Approved the following recommendation:

That the Committee on Long-Range Planning and Development be charged with completing a review of the committee structure of the Medical Society of New Jersey.

Old Business . . .
Appointment of a Committee to Study Peer Review Organization (PRO) . . . Empowered the President to appoint a committee to study PRO and the possibility of MSNJ applying for agent status.

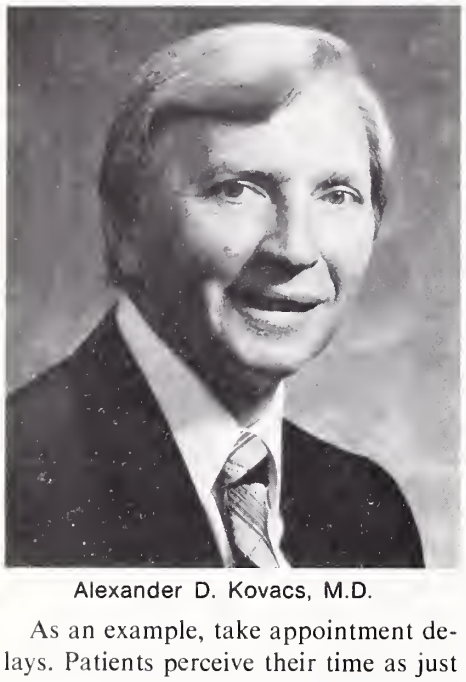
New Business . . .
Seating of State Medical Society Presidents at Meetings of the AMA House of Delegates . . . Directed that the Committee on Revision of Constitution and Bylaws prepare the appropriate amendment to MSNJ's bylaws stating that the current president of a constituent medical association also may be certified as an additional alternate delegate at the discretion of each constituent medical association.
Note: This amendment was adopted at the 1983 AMA Interim Meeting.

President's Column

Alexander D. Kovacs, M.D.

Sometimes we are our own worst enemy. We wonder why we do not get respect and are thought of as being money hungry and lacking concern for our patients.

Have you ever stood back and observed yourself through another's eyes? Introspective analysis can help your patient relations. Observe your telephone manners and those responsible for your messages or appointments. Are you or your associates curt, unsympathetic, or unaccommodating? Are you or your associates courteous, compassionate, helpful, and informative?



Alexander D. Kovacs, M.D.

As an example, take appointment delays. Patients perceive their time as just as important as yours. If there is going to be more than a 20-minute delay in office appointments, does your assistant or nurse explain the problem and offer to change the appointment or call to delay the later ones?

Are you stand-offish or grouchy or are you pleasant, permitting the patient to ask questions and to participate in treatment decisions? Do you make sure he/she understands how to take the medication? Do you allow your medical assistant to reinforce your instructions or to ask patients if they understand what they are to do? Do you explain the reason for the tests you plan to order and their possible costs? Do you come across like "big daddy" telling the child what to do? Is your "God complex" showing again?

The telephone manners of your staff may make or break an office. After all, this is the first and last contact with your office. No matter how good a doctor you are, first impressions are lasting! Listen in on your front office occasionally. A missed message or poor communication can lead to a malpractice suit.

Does your front office handle fee information and bill collecting properly without antagonizing the patient? Does your staff help patients fill out their insurance forms even though you expect payment in cash or check? Perhaps you could use "super bills" which are attached to their insurance forms. This entails less work for your assistant.

Encourage your assistant to join and attend meetings of the Medical Assistants Association. In fact, pay the dues.

Do you explain hospital charges to your patients? Are you sympathetic if the patient has a serious disease? This may be old hat to you but may be terrifying to the patient. I dare say we will not face our own demises with any more equanimity than our patients show.

We can harvest complaints about our concern for the hospitalized patient. The most common complaint is that the doctor only came in for a few seconds, said hello, and rushed right out. Why not enter the room leisurely (even though you may be in a hurry), sit down on a chair or the bed, hold the patient's hand or forearm, and talk to her/him. Take your chart into the room and write on it right there in front of the patient while you are discussing his or her progress and show some of the test results. You have to look at the chart anyway, so show the patient the hospital visit is more than just running in and out of the room. If it is a social visit or if the patient is under someone else's care, do not charge a visiting fee. Do not charge an "admission fee" to the hospital—instead a "time spent for history and physical fee" or "treatment evaluation fee." The terminology "admission fee" creates patient resentment.

If you are a consultant, tell the patient who you are, why you were called, and that there will be a fee involved and whether insurance will cover the visit. Nothing is more distressing to a patient than to receive a bill for a large consultation fee when he or she does not know who the consultant is or how this doctor got involved.

The art of the practice of medicine or surgery goes beyond technical skill. The cognitive skills in medicine are more than observation and evaluation. Cognitive means "to recognize, be aware, and be sensitive to." Let us try to be cognitive not just of the patient's disease but of that very human person who is the patient.

UMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

According to a report compiled by t Office of the Registrar and presented the university's Board of Truste female enrollment at UMDNJ has co tinued to rise steadily since 1969. Fort four percent of UMDNJ's 2,401 st dents are women, as compared to a 3 percent enrollment in 1969.

There are 250 women (37.7 percent) UMDNJ-New Jersey Medical Schoo which has for several years maintaine one of the highest percentages of fema medical students in the country. Th largest single group of women student 433, is at the School of Health-Relate Professions.

The remaining breakdown is as fo lows: 92 female students at New Jerse Dental School; 48 at the School of O teopathic Medicine; 124 at Rutge Medical School, Piscataway; 29 a Rutgers Medical School, Camden; 43 a the Graduate School of Biomedical Sc ences; 7 in the postgraduate programs c New Jersey Dental School; and 46 in th graduate public health program offere jointly by Rutgers Medical School an Rutgers, the State University.

UMDNJ has been awarded $400,00 to establish a laboratory on its Newarl campus to further research and patien care efforts in the battle against acquire immunodeficiency syndrome (AIDS) The funds, part of the total $530,00 appropriated this summer by the Stat Legislature for a comprehensive AIDS program, will be used for staff and equipment for the laboratory. The mos important piece of equipment will be a quarter-million dollar Fluorescence Activated Cell Sorter that incorporates computer and laser technology and is capable of analyzing 5,000 blood cells per second.

Two standard laboratories currently are being transformed into a 1,800 square-foot laboratory and "P3" containment facility to be called the Pediatric Cellular Immunology Laboratory. The P3 status is the second highest designation by the federal government for facilities involved in research with possible contaminants.

The laboratory, to be completed in 1984, will be located in the Medical Science Building and will be under the direction of James M. Oleske, M.D. Dr. Oleske, a prominent expert on AIDS who was one of the first investigators to identify the disease in children, is associate professor of pediatrics with a

oint appointment in preventive medine and community health at UMDNJew Jersey Medical School.

The first pregnancy resulting from ew Jersey's only in vitro fertilization rogram was announced by Dr. Ekehard Kemmann, director of the proram and chief of the division on reproductive endocrinology and fertility at Middlesex General-University Hospital, lew Brunswick. The program, jointly ponsored by the hospital and UMDNJ-Rutgers Medical School, where Dr. Kemmann is associate professor, began dmitting patients in May 1983.

UMDNJ has joined Rutgers, the State University, to begin the first Masters of ublic Health Program in the state with 0 students enrolled in the new program.

Administered by the Department of nvironmental and Community Medine, UMDNJ-Rutgers Medical School, vith courses held at the Rutgers-New Brunswick campus, the program offers major in one of four specialty areas; nvironmental health; health educaion/behavioral sciences; occupational ealth; and biostatistics. Planned for the pring semester is a specialty in health are organization and administration, vith epidemiology scheduled for the 984 to 1985 academic year. Other pecialty areas will be developed to meet tudent needs.

New Jersey is an important laboratory or the study of the relationship between ndustrialization, urbanization, and pubic health. This program, which stresses nvironmental and occupational health, will not only help meet the state's need for health professionals, but also will address critical public health problems in our state.

MSNJ Auxiliary

Gale Wayman
President

As promised several months ago, I will elaborate on the AMPAC Political Education Conference held in Washington, D.C., this past fall. "Participation 84" was the theme and AMPAC is encouraging the active involvement of AMA members and their families in the 1984 presidential campaign. In so doing, AMPAC is seeking to promote better government and to ensure the concerns of the medical profession. The AMA directly will help in the process by committing such resources as training seminars, publications, meetings, and special communications. It also is bringing these seminars to the states, with one, hopefully, in New Jersey this spring.

While in Washington, we learned something of "party leadership" from Senators Ted Stevens (Alaska) and Lloyd Bentsen (Texas). A feisty Senator Robert Dole gave us insight into what is happening in Washington and we were let in on some White House information from Ed Meese, counselor to the President. All these "big guns" of politics had one clear message: if we, the medical profession, do not become involved in politics, we will be forgotten. It is the squeaky wheel that gets the oil!

It was very gratifying to see in the November *AMPAC Sustainer* that one of New Jersey's physicians is doing an outstanding job of getting involved. Dr. Peter Amirata, President of Essex County, has marshaled a steering committee of physicians to help raise membership and funds—in four months he has been able to raise $17,000 and obtain 175 members in Essex County. This is in comparison to last year's state figure of $14,000.

The Auxiliary is working with its members for more participation, but let us all try to get involved.

AMNJ Report

Paul J. Hirsch, M.D.
President

During the past year the Academy of Medicine has continued to expand its primary roles, and has added a number of significant new member benefits.

The Academy of Medicine is the statewide organization responsible for accreditation of continuing medical education in New Jersey. Any meeting, conference, or program submitted for approval is evaluated carefully by the Academy staff, and by the Education Committee. The Academy maintains high standards for the quality of continuing medical education in New Jersey.

In addition, the Academy of Medicine sponsors educational programs to meet the needs of practicing physicians. These programs include the roving symposia, or major symposia series, individual programs, and programs sponsored in association with the Medical Society of New Jersey, the specialty societies, and other organizations and institutions in our state. In all of these, the quality of education is high, and the cost to physicians has been kept quite moderate. These educational activities of the Academy of Medicine are supported by, and run by, the practicing physicians of New Jersey. In planning programs, the Academy recognizes and evaluates educational needs and educational wants of the medical community. The Academy now is in the process of developing a more formal process to assess these wants and needs.

The Academy of Medicine provides administrative and secretarial services for most of the specialty societies in New Jersey. Twenty-six societies now utilize these services. This process has brought together many of these organizations, and has helped to unite the physicians in different specialties, in many common purposes.

Despite the success of the Academy of Medicine, we continue to improve our programs, and to seek additional ways in which to better serve our membership. During the past year, we have initiated a computerized program to record the CME credits of AMNJ members; twice each year, members receive a computerized printout of all courses attended, whether sponsored by the Academy or not. We now send a useful monthly program booklet, listing educational programs available in New Jersey, indexed by specialty. We have initiated the "First Wednesday" program, to bring to the Academy speakers of significance on socioeconomic topics. We are expanding our Speaker's Bureau program to include a separate Speaker's Bureau for community groups; organizations requesting medical speakers will be given the names of Academy members in their areas. The Academy continues to provide excellent library services through the University of Medicine and Dentistry of New Jersey.

Among other important and worthwhile functions of the Academy of Medicine, I would note particularly the annual Edward J. Ill Award to an outstanding physician in New Jersey. We believe that it is important to recognize leadership in the medical community. Although membership in the Academy is considered in determining this Award, all physicians are eligible and may be nominated.

Finally, the Academy strongly supports the purposes and tasks of the Medical Society of New Jersey. Indeed, the identification of the Academy of Medicine with the Medical Society has been so great, that many members of MSNJ have felt that they are "automatically" members of the Academy. This is not so. Although the Academy is considered "the teaching arm of the Medical Society of New Jersey," it is a separate

organization, with separate membership. We would encourage all members of MSNJ to be Fellows of the Academy, and to support quality continuing medical education in our state, based upon the needs of the practicing physician.

Task Force on Fetal Alcohol Syndrome

The Chairman of the Subcommittee on Newborn Record Keeping reported that a Task Force on Fetal Alcohol Syndrome was formed under the New Jersey Division of Alcoholism. The Task Force will plan strategies to address the problems of fetal alcohol syndrome by developing a systematic approach toward accurate identification of women-at-risk, and appropriate intervention and treatment strategies for mothers and children.

The following recommendation was approved by the Board of Trustees: That the Medical Society of New Jersey endorses the educational goals of the Task Force on Fetal Alcohol Syndrome and urges all physicians caring for women of childbearing age to bring the dangers of drinking to their attention.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY—Jan Charles Horrow, M.D., 131 Pond Brook Rd., Chestnut Hill, MA 02167. Pennsylvania 1977. Board certified. Group, academia, HMO. Available.

CARDIOLOGY—Aubrey Orrin Lewis, M.D., 200 Carman Ave., Apt. 21-F, East Meadow, NY 11554. SUNY-Syracuse 1979. Also, general internal medicine. Board certified (IM). Solo, partnership, group, academia (cardiology). Available July 1984.

Lt. Gary P. Schwartz, M.D., USAF, 8 Lodge Dr., Rockville, MD 20850. SUNY-Upstate 1968. Board certified. Single specialty, multispecialty group, partnership. Available September 1984.

FAMILY MEDICINE—Jaime F. Lara, M.D., 6045 Palisade Ave., West New York, NJ 07093. Seville (Spain) 1979. Board eligible. Partnership or institutionally based. Available.

GASTROENTEROLOGY—Albert M. Harary, M.D., 2121 N. Bayshore Dr., Apt. 1001, Miami, FL 33137. Columbia 1978. Also, general internal medicine. Board certified (IM). Group, partnership, solo. Available July 1984.

P. Kothanda Raman, M.D., 9 Lake Ave., Apt. 5A, East Brunswick, NJ 08816. Stanley Medical College (India) 1977. Board eligible (IM). Also internal medicine. Partnership, group, solo. Available July 1984.

INTERNAL MEDICINE—Nicholas Bertini, M.D., 663 Hudson Ave., Albany, NY 12203. SUNY-Buffalo 1980. Board eligible. Group, partnership, solo. Available June 1984.

Harold J. Brown, M.D., 260 Eggerts Rd., Lawrenceville, NJ 08648. UMDNJ 1982. Primary care clinic, HMO, group, partnership. Available July 1985.

Palamadai S. Duraiswami, M.D., 64-A Oneida Ave., Centereach, NY 11720. Stanley Medical College (India) 1976. Board eligible. Available.

Elliott Friedman, M.D., 25 Penny La., Baltimore, MD 21209. SUNY-Syracuse 1978. Subspecialty, endocrinology. Board certified (IM); board eligible (endocrinology). Group or partnership (both specialties). Available July 1984.

Lee W. Hoffer, M.D., 1017 East 80th St., Brooklyn, NY 11236. Rome (Italy) 198(Solo, partnership, group. Available.

Arvind Mehta, M.D., 8051 N. Hanover St., Anaheim, CA 92861. Seth G.S. Medic College (India) 1975. Also, nephrolog Board eligible. Solo, group, associat Available.

P. Kothanda Raman, M.D., 9 Lake Ave Apt. 5A, East Brunswick, NJ 0881(Stanley Medical College (India) 197 Board eligible. Also, gastroenterolog Partnership, group, solo. Available Jul 1984.

Steven Wolinsky, M.D., 1404 E. 15 St Brooklyn, NY 11230. Case Western Re serve 1980. Group or partnership. Avai able July 1984.

NEPHROLOGY—Arvind Mehta, M.D. 8051 N. Hanover St., Anaheim, CA 92861 Seth G.S. Medical College (India) 1975 Also, internal medicine. Board eligible Solo, group, partnership. Available.

NEUROLOGY—Elizabeth Kamenar, M.D. 12701 Shaker Blvd., Apt. 410, Cleveland. OH 44120. Ohio State 1975. Board eligible. Group, partnership, academia. Available July 1984.

Robert P. Rubens, M.D., 105 Ward St., Apt. 204, Seattle, WA 98109. UMDNJ-New Jersey Medical School 1980. Board eligible. Available July 1984.

OBSTETRICS/GYNECOLOGY—Alan M. Askinas, M.D., 1309 Carrollton, Apt. 321, Metairie, LA 70005. Illinois 1980. Board eligible. Group, partnership, solo, part academia. Available July 1984.

Wook Chung, M.D., 2212 Watterworth Dr., Kalamazoo, MI 49008. Catholic Medical College (Korea) 1967. Board certified. Solo, group, partnership. Available.

Iris E. Dominy, M.D., 108 Pinegate Circle, Apt. 2, Chapel Hill, NC 27514. Albany 1978. Board eligible. Partnership or group in metropolitan area. Available July 1984.

OPHTHALMOLOGY—Steven R. Davis, M.D., 1000 Lakeview Rd., Clearwater, FL 33516. University of Alabama 1975. Board certified. Solo or association. Available.

Andrew Gewirtz, M.D., 519 Beach 133 St., Belle Harbor, NY 11694. Chicago 1978. Board eligible. Board certified (pediatrics). Group or partnership. Available July 1984.

PATHOLOGY—Mark A. Grathwhol, M.D., 2510 West Tremont Ct., Richmond, VA 23225. NYU 1980. Group. Available July 1984.

Yury Kogan, M.D., 60 Egmont St., Brookline, MA 02146. Moscow 1967. Hospital or group. Available July 1984.

PEDIATRICS—Jonathon J. Evans, M.D., 1800 Calvin Ct., #6, Iowa City, IO 52240. Univ. of California-San Diego 1981. Board eligible. Group or HMO. Available July 1984.

Michael J. Foreman, M.D., 2527 Hydraulic Rd., #52, Charlottesville, VA 22901. Hahnemann 1981. Board eligible. Group or partnership. Available July 1984.

218th Annual Meeting
May 2-6, 1984

Resorts International
Atlantic City

Fill out the Application Form
Page 142

Howard Mintz, M.D., 60 Presidential Plaza, Apt. 308, Syracuse, NY 13202. Pittsburgh 1981. Board eligible. Group or partnership. Available July 1984.

SYCHIATRY—Eric M. Levin, M.D., 43 West 8th St., Media, PA 19063. La Faculté Libre de Medicine (Spain) 1980. Board eligible. Group, institutionally based, CMH outpatient. Available July 1984.

ULMONARY DISEASES—James Kohan, M.D., 19 Highmanor Dr., Henrietta, NY 14467. Virginia 1979. Also, general internal medicine. Board certified (IM). Group, partnership, solo, institutional. Available July 1984.

Dinesh Talati, M.D., 66-02 Grand Central Pkway., Forest Hills, NY 11375. B.J. Medical College (India) 1974. Board eligible. Solo, group, partnership. Available July 1984.

ADIOLOGY/NUCLEAR MEDICINE—Conrad P. Erlich, M.D., 1243 Beacon St., Apt. 3B, Brookline, MA 02146. Boston 1976. Board certified. Group or partnership. Available July 1984.

Mindy M. Horrow, M.D., 131 Pond Brook Rd., Chestnut Hill, MA 02167. Med College of Pennsylvania 1980. Board eligible. Group, HMO, academia. Available.

HEUMATOLOGY—Richard Furie, M.D., 435 E. 70th St., Apt. 8-F, New York, NY 10021. Cornell 1979. Also, general internal medicine. Board certified (IM). Group, partnership, solo. Available July 1984.

URGERY, GENERAL—Ramon J. Gomez, M.D., 40-71 Gleane St., Elmhurst, NY 11373. University of the East (Philippines) 1978. Group or hospital-based emergency medicine practice. Available.

Ravinder Jagpal, M.D., 3408 Balboa La., Apt. 33, Columbia, MO 65201. Rutgers 1981. Also, cardiothoracic surgery. Board certified (S); board eligible (TS). Group. Available July 1984.

URGERY, ORTHOPEDIC—Jeffrey H. Charen, M.D., 155 Lexington St., Apt. 15, Auburndale, MA 02166. Rochester 1978. Board eligible. Group, partnership, solo (central or northern NJ preferred). Available January 1984.

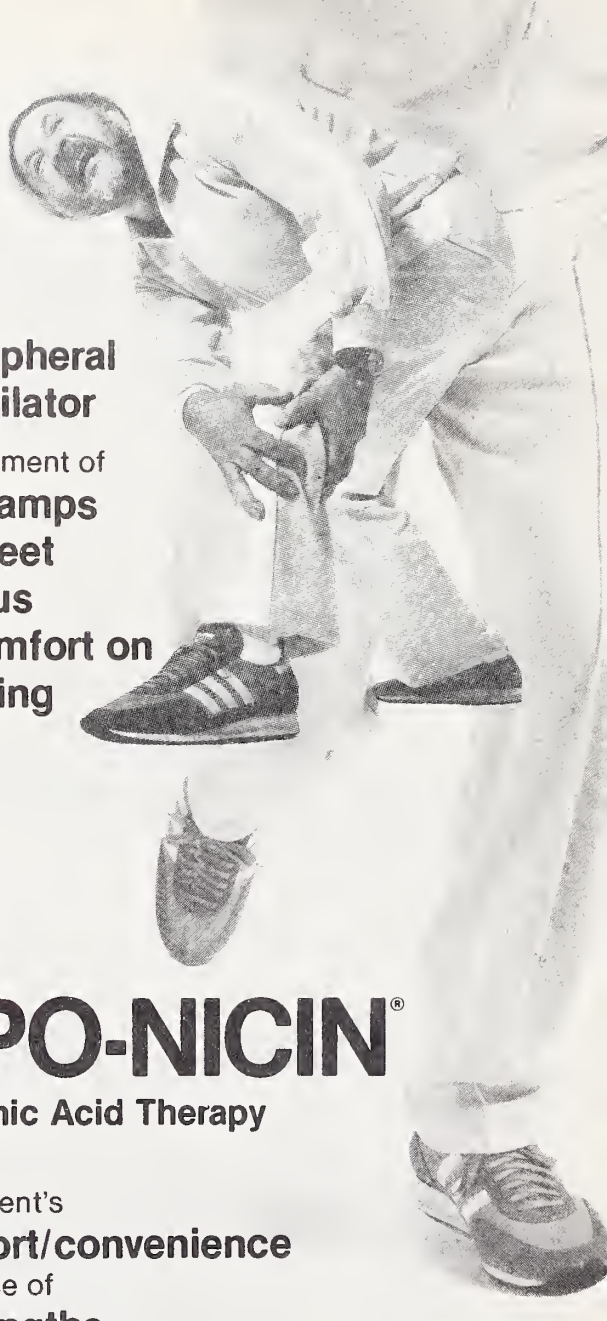
Salvatore Inserra, M.D., 1847 79th St., Brooklyn, NY 11214. NYU 1979. Board eligible. Group, partnership, solo. Available July 1984.

Richard Lebovicz, M.D., 415 Grand St., New York, NY 10002. SUNY-Downstate 1979. Group or partnership. Available July 1984.

Oscar A. Reicher, M.D., 71 Brookwood Ter., Nashville, TN 37205. Pittsburgh 1979. Solo or group. Available July 1984.

UROLOGY—Joseph G. Colonna, M.D., 1234 Van Voorhis Rd., Apt. C-6, Morgantown, WV 26505. Guadalajara (Mexico) 1977. Board eligible. Group or partnership. Available October 1984.

Barlow S. Lynch, M.D., 5145 Linda Lou Dr., Carmichael, CA 95608. SUNY-Buffalo 1977. Board eligible. Partnership, group, solo, academia. Available July 1984.



A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release
LIPO-NICIN®/300 mg.

Each time-release capsule contains:
Nicotinic Acid .....300 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release
LIPO-NICIN®/250 mg.

Each yellow tablet contains:
Nicotinic Acid .....250 mg.
Niacinamide .....75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide .....75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

LIKOFF CARDIOVASCULAR INSTITUTE

of Hahnemann Medical College & Hospital

230 N. Broad Street, Philadelphia, Pennsylvania 19102 (215) 448-8063

CARDIOLOGY UPDATE. . .

IS DESIGNED FOR THE PHYSICIAN AND PROVIDES AN INTENSIVE SURVEY OF THE CURRENT STATUS OF CLINICAL CARDIOLOGY. . .

WEDNESDAY, MARCH 7, 1984

CARDIAC FAILURE

MODERATOR: WILLIAM LIKOFF, M.D.

3:00	CASE PRESENTATION	*William Likoff, M.D.*
3:00	THE PATHOPHYSIOLOGY OF CONGESTIVE FAILURE	*Irving M. Herling, M.D.*
4:00	THE OVERT AND SUBTLE CLINICAL MANIFESTATIONS OF CARDIAC FAILURE	*Abdulmassih S. Iskandrian, M.D.*
4:30	RENAL FUNCTION IN PATIENTS WITH CARDIAC FAILURE	*David T. Lowenthal, M.D.*
5:00	NEWER DRUGS FOR SEVERE AND REFRACTORY CARDIAC FAILURE	*Mariell J. Likoff, M.D.*
5:30	PANEL DISCUSSION	

LECTURE HALL "A"—2nd floor New College Building, Hahnemann University
15th and Vine Streets, Philadelphia, PA

• NO REGISTRATION FEE • NO ADVANCE REGISTRATION REQUIRED •
• CME CATEGORY I CREDITS CERTIFIED •
WINE & CHEESE SERVED FOLLOWING CONFERENCE

University of Pennsylvania School of Medicine

Trends in Clinical Nutrition

Eighth Annual Nutrition Symposium April 3-5, 1984

Dunlop Auditorium, University of Pennsylvania
School of Medicine, Philadelphia

Philadelphia Veterans Administration Medical Center

The purpose of this program is to provide the practicing physician, clinical dietitian, nurse, and pharmacist with a clinical approach to commonly encountered diagnostic and therapeutic problems in adult clinical nutrition.

Discussion Topics:
Nutrition and Aging, Nutrition in Liver Disease, Enteral Alimentation-Alternative Approaches, Complications of Long-Term Parenteral Nutrition, Nutrition and Sepsis, History and Future of Specialized Nutrition Support, Anorexia Nervosa, Credentialing of Nutrition Support Professionals, Respiratory Considerations and Energy Expenditure, and Enteral vs Parenteral Nutrition.

Continuing Education Credits:
Approval has been granted for credits for dietitians, nurses, pharmacists, and physicians.

Course Directors:
James L. Mullen, M.D., Chief, Surgical Service, Philadelphia VA Medical Center; Director, Nutrition Support Service, Hospital of the University of Pennsylvania; Associate Professor of Surgery, University of Pennsylvania.

Wanda Hain Howell, R.D., M.Ed., Nutrition Education Specialist, Nutrition Support Service, Hospital of the University of Pennsylvania

Registration Fee: $100

Guest Faculty:
Jeffrey Askanazi, M.D.
George Blackburn, M.D., Ph.D.
Rex Brown, Pharm.D.
Frank Cerra, M.D.
Loretta Forlaw, Maj., A.N.C.
David Lipschitz, M.D., Ph.D.
Carol Mitchell, Ph.D., R.D.
Theodore Reiff, M.D.
Barney Sellers
William Steffee, M.D., Ph.D.

For Information and Registration, contact:
Office of Continuing Medical Education
School of Medicine/G3
University of Pennsylvania
Philadelphia, PA 19104
(215)898-8005

CME CALENDAR

This list is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the University of Medicine and Dentistry. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

Mar.

9, 10, 11 25th Postgraduate Anesthesia Seminar
8 A.M.—Hyatt, Cherry Hill
(NJ State Society of Anesthesiologists and AMNJ)

Apr.

16 Pain Therapy
11:30 A.M.- 12:30 P.M.—Columbus Hospital, Newark
(AMNJ)

CARDIOLOGY

Mar.

7 Noninvasive Testing in Cardiovascular Disease
9-11 A.M.—Middlesex General Hospital, New Brunswick
(Middlesex General Hospital and AMNJ)

7, 14, 21, 28 Cardiology
3-6 P.M.—Overlook Hospital, Summit
(Overlook Hospital and AMNJ)

20 Current Therapy of Acute Myocardial Infarction
12 noon—St. Mary's Hospital, Orange
(AMNJ)

Apr.

17 Management of Unstable Angina
12 noon—St. Mary's Hospital, Orange
(AMNJ)

25 Management of Acute Myocardial Infarction
1-2:30 P.M.—VA Medical Ctr., Lyons
(VA Medical Ctr. and AMNJ)

MEDICINE

Mar.

1 Medical Grand Rounds
9:30 A.M.—Newark Beth Israel Medical Ctr.
(Endocrinology Section, AMNJ)

1, 15 Effects of Stress on Disease
Heart Disease, Lipoproteins, and Nutritional Counseling
11 A.M.—St. Joseph's Hospital and Medical Center, Paterson
(St. Joseph's Hospital and UMDNJ)

2 Medical Grand Rounds
11:30 A.M.—University Hospital, Newark
(Endocrinology Section, AMNJ)

2, 16 Renal Conferences in Nephrology
4-5 P.M.—UMDNJ-University Hospital, Newark
(Nephrology Society of NJ and Nephrology Section, AMNJ)

6 Nutrition Support—Middle Age and the Elderly
11 A.M.- 12 noon—Greystone Park Psychiatric Hospital
(AMNJ)

7 Medical Grand Rounds
11:30 A.M.—VA Medical Ctr., East Orange
(Endocrinology Section, AMNJ)

7 Hypertension
1:30 P.M.—Essex County Hospital Ctr., Cedar Grove
(AMNJ)

7, 21 Angina
Obstructive Uropathy
1-2:30 P.M.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

7, 14, 21, 28 Endocrine Conferences
3:30-5 P.M.—Rotates between Newark Beth Israel Medical Ctr., UMDNJ-University Hospital, and United Hospitals Medical Ctr., Newark, and VA Medical Ctr., East Orange
(Endocrinology Section, AMNJ)

8 Pain Therapy
2 P.M.—John E. Runnells Hospital of Union County, Berkeley Heights
(AMNJ)

13, 22, 29 Diet and Cancer
Detection and Diagnosis
Principles of Patient Management
4-6 P.M.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

13 Blood Banking Seminar
2-5 P.M.—Rutgers Medical School, Piscataway
(NJ Blood Services and AMNJ)

15 Current Approaches to Irritable Bowel Syndrome
5-6:30 P.M.—Somerset Medical Ctr., Somerville
(Somerset Medical Center and AMNJ)

20 Emergency Care—Cardiac Drug Overdose
11 A.M.- 12 noon—Greystone Park Psychiatric Hospital
(AMNJ)

20 Hypertension
1:30-2:30 P.M.—Essex County Hospital, Cedar Grove
(AMNJ)

20 Regional Nephrology Conferences
4-5 P.M.—Academic Health Science Ctr.
(UMDNJ-Rutgers Medical School and AMNJ)

21 Dermatological Conference
6-9 P.M.—Rutgers Community Health Plan, 57 U.S. Hwy. 1, New Brunswick
(UMDNJ-Rutgers Medical School and AMNJ)

21 Significance and Treatment of Common Abnormalities in Serum Electrolytes and/or Acid-Base Balance

28 Antibiotic and Antiviral Agents in an Office Practice
9-11 A.M.—Middlesex General Hospital, New Brunswick
(Middlesex General Hospital and AMNJ)

28 Extended Spectrum Penicillin and Cephalosporins
10:30 A.M.- 12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

28 Implications of Clinical Trials on Management of Mild Hypertension
1-2:30 P.M.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

28 Dermatology
3-6 P.M.—Overlook Hospital, Summit
(Overlook Hospital and AMNJ)

Apr.

2 Laser Treatment—GI
1:30 P.M.—Columbus Hospital, Newark
(AMNJ)

4 Medical Grand Rounds
11:30 A.M.—VA Medical Center, East Orange
(Endocrinology Section, AMNJ)

4 Alcoholism
1:30 P.M.—Essex County Hospital Ctr., Cedar Grove
(AMNJ)

4 Antibiotic Nephrotoxicity
1-2:30 P.M.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

4 Hypertension in the Elderly

4, 25 Paget's Disease
1-2:30 P.M.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

4 Cutaneous Manifestations of Systemic Diseases

11 Medical Treatment of Gallbladder Disease

18 Osteoporosis and Kidney Stones

25 The Powerful New Role of Monoclonal Antibodies in Medical Diagnosis and Treatment
9-11 A.M.—Middlesex General-University Hospital, New Brunswick
(Middlesex General-University Hospital and AMNJ)

4, 11, 18, 25 Endocrine Conferences
3:30-5 P.M.—Rotates between Newark Beth Israel Med. Ctr., University Hospital, and United Hospitals Medical Ctr., Newark, and VA Medical Center, East Orange
(Endocrinology Section, AMNJ)

5 Medical Grand Rounds
9:30 A.M.—Newark Beth Israel Medical Ctr.
(Endocrinology Section, AMNJ)

ACUPUNCTURE IN CLINICAL PRACTICE

N.Y. State Boards of Medicine & Dentistry 25-hour accredited seminar and workshop on the latest theories & techniques of manual and electro-acupuncture, applicable toward the 200-hour requirement for certification, will be given for licensed clinicians (with or without prior training) during the weekend of January 27-29, 1984 and again the weekend of March 23-25, 1984 at the Barbizon Plaza Hotel, New York City. Co-sponsored by the International College of Acupuncture & Electro-Therapeutics, its official journal (published by Pergamon Press) the Heart Disease Research Foundation and the Neuroscience Dept. of Long Island College Hospital, Pharamcology Dept. of The Chicago Medical School. Also eligible for AMA/CME credit. For information, contact Y. Omura, M.D., ScD., 800 Riverside Drive (8-1), NYC 10032. Tel: (212) 781-6262 or (212) WA8-0658, or Saul Heller, M.D., Tel: (212) 838-7514.

NYU MEDICAL CENTER

Post-Graduate Medical School

March	
12-16	**Managing Clinical Problems in the Elderly (Cerromar Beach Hotel/Puerto Rico)**
19-23	Seminar in Advanced Rheumatology
26-30	Anesthesiology: Comprehensive Review III
April	
26-28	Update in Clinical Dermatology

Information: NYU Post-Graduate Medical School, 550 First Avenue, New York, NY 10016 (212) 340-5295.

THE ACADEMY OF MEDICINE OF NEW JERSEY

in cooperation with

SAINT BARNABAS MEDICAL CENTER

presents
a symposium on

"MANAGEMENT OF PATIENTS WITH LOW VISION"

Saturday, March 31, 1984
8:15 a.m.-4:30 p.m.
at
SAINT BARNABAS MEDICAL CENTER
Livingston, N.J.

The program will provide a complete and practical presentation of all aspects of management of the patient with low vision, and will include presentations by nationally prominent speakers on low vision corrections for distance and near; methods of testing and recording vision; corrections related to field defects; illumination; optical aids; Corning photochromatic filters; genetic counseling; management of low vision in children; favorable and unfavorable patients; social, educational and rehabilitation services for the partially sighted patient; and telescopic spectacles. The program is designed for ophthalmologists, optometrists, opticians and other interested professionals.

Program Chairman: Gerald Fonda, M.D.
Director, Low Vision Center
Saint Barnabas Medical Center

For further information contact:
EXECUTIVE OFFICES
The Academy of Medicine of New Jersey
Two Princess Road, Lawrenceville, NJ 08648
(609) 896-1717

Eighteenth Annual Main Life Conference

"CURRENT CONCEPTS IN MEDICINE FOR THE PRACTICING PHYSICIAN"

Thursday, Friday and Saturday May 3, 4 and 5, 1984
VALLEY FORGE HILTON • KING OF PRUSSIA, PA.

Sponsored by
THE BRYN MAWR HOSPITAL
In affiliation with Jefferson Medical College

PROGRAM INCLUDES: • Unknown Fever • Obesity and Anorexia • Hypertension • Arrhythmias • Oliguria • Breast Cancer • Hormone Therapy • Diabetes • Which Test? • 26 Concurrent Clinics

GUEST SPEAKERS INCLUDE: • Charles A. Kallick, M.D., *Cook County Hospital* • Richard S. Rivlin, M.D., *Memorial Sloan-Kettering Cancer Center* • Arnold E. Andersen, M.D., *Johns Hopkins Medical Institutions* • Joseph N. DiGiacomo, M.D., *University of Pennsylvania* • Alvin F. Goldfarb, M.D., *Jefferson Medical College* • J. Ingram Walker, M.D., *Duke University Medical Center*

ACCREDITATION:
AMA
As an organization accredited for continuing medical education, the Jefferson Medical College designates this continuing medical activity as meeting the criteria for 20 credit hours in Category I of the Physician's Recognition Award for the American Medical Association
PMS
AAFP
This program has been reviewed and is acceptable for 20 Prescribed hours by the American Academy of Family Physicians.
AOA and ACGPOMS approved

FOR INFORMATION WRITE:

HAROLD J. ROBINSON, M.D.
Director, Main Line Conference
The Bryn Mawr Hospital
Bryn Mawr, Pennsylvania 19010

Registration Fee: **$185.00**
(includes 3 luncheons, cocktails and dinner)

5 **Psychosocial Care and Unorthodox Cancer Therapies**
4-6 P.M.—Institute for Medical Research Copewood St., Camden
(Institute for Medical Research and AMNJ)

6 **Medical Grand Rounds**
11:30 A.M.—University Hospital, Newark
(Endocrinology Section, AMNJ)

6 **Renal Conferences in Nephrology**
20 4-5 P.M.—University Hospital, Newark
(Nephrology Society of NJ and Nephrology Section, AMNJ)

13 **Controversies in the Management of Otitis Media**
8-9:30 A.M.—Overlook Hospital, Summit
(Overlook Hospital and AMNJ)

17 **Laser Treatment of Massive Gastrointestinal Hemorrhage**
11 A.M.- 12 noon—Greystone Park Psychiatric Hospital
(Greystone Park Psychiatric Hospital and AMNJ)

17 **Renal Osteodystrophy**
4-5 P.M.—Academic Health Science Ctr., New Brunswick
(UMDNJ-Rutgers Medical School and AMNJ)

18 **Substance Abuse and Misuse**
8:30 A.M.- 1 P.M.—Medical Society of New Jersey, Lawrenceville
(NJ State Department of Health, MSNJ, and AMNJ)

18 **Dermatological Conference**
6-9 P.M.—Rutgers Community Health Plan, 57 U.S. Hwy. 1, New Brunswick
(UMDNJ-Rutgers Medical School and AMNJ)

18 **William P. Burpeau Annual Award Dinner**
6:30 P.M.—The Manor, West Orange
(Urology Section, AMNJ)

24 **How Scientific Is Modern Medicine?**
7:30-8:30 P.M.—Ramada Inn, Exit 135, Garden State Parkway
(Nephrology Section of NJ and AMNJ)

26 **Renal Hemodynamics of Hypertension**
11 A.M.- 12:30 P.M.—St. Joseph's Hospital, Paterson
(St. Joseph's Hospital and Medical Center and AMNJ)

26 **Regional Hospital Meeting**
8-10 P.M.—Overlook Hospital, Summit
(NJ Gastroenterological Society and AMNJ)

NEUROLOGY/PSYCHIATRY

Mar.

1 **Pharmacotherapeutic Agents in the Management of Borderline-Personality Disorders**

3 **Depression: Differential Diagnosis, and Newer Methods of Treatment**
1-2:30 P.M.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

8 **Advances in Neuroleptic Medication**

15 **Alone—Yearning for Companionship**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

6 **Is There a Devil?**
8:15-10:30 P.M.— 39 Crescent Ave., Passaic
(Essex Psychiatric Seminar and AMNJ)

7 **Group Therapy**
21 2-3 P.M.—Ancora Psychiatric Hospital, Hammonton
(Ancora Psychiatric Hospital and AMNJ)

9 **Psychiatric Lecture Series**
16 1:30-5 P.M.—Trenton Psychiatric Hospital
23 *(Trenton Psychiatric Hospital and*
30 *AMNJ)*

14 **Anxiety and Neurosis**
9-11 A.M.—Middlesex General Hospital, New Brunswick
(Middlesex General Hospital and AMNJ)

15 **Aspects of Anorexia Nervosa**
8-10 P.M.—Hackensack Hospital
(NJ Psychoanalytic Society and AMNJ)

19 **Principles of Child Psychotherapy**
8:30-10:30 P.M.—Office of Dr. Deutsch, 301 Broad St., Englewood
(NJ Psychoanalytic Society and AMNJ)

21 **Tardive Dyskinesia and Other Movement Disorders**
9 A.M.- 4:45 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

20 **Acid-Based Electrolyte Abnormalities Associated with Drugs**
11 A.M.- 12 noon—Greystone Park Psychiatric Hospital
(AMNJ)

Apr.

2 **Identify Disorder Versus Borderline Personality**
8:15-10:30 P.M.— 5 Fairfield St., Montclair
(Essex Psychiatric Seminar and AMNJ)

3 **Strokes C.V.A.—Post and Rehabilitation Care**
11 A.M.- 12 noon—Greystone Park Psychiatric Hospital
(Greystone Park Psychiatric Hospital and AMNJ)

5 **Behavior Medicine and Biofeedback**

12 **Treatment Issues of the Depressed Woman**

19 **Cross-Cultural Psychiatry**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

6 **Psychiatric Lecture Series**
13 1:30-5 P.M.—Trenton Psychiatric Hospital
27 *(Trenton Psychiatric Hospital and AMNJ)*

9 **Developmental-Behavioral Disorders:**
10 **Update 1984**
11 Glenpointe Hotel, Teaneck
12 *(Hackensack Medical Center and*
13 *AMNJ)*

11 **The Sleepless Patient**
9:15 A.M.- 4:30 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

11 **Update in Psychosomatic Medicine**
2-5 P.M., 7-9 P.M.—Stony Hill Inn, Hackensack
(North Jersey Psychiatric Society and AMNJ)

16 **Principles of Child Psychotherapy**
8:30-10:30 P.M.— 301 Broad Ave., Englewood
(NJ Psychoanalytic Society and AMNJ)

18 **Group Therapy**
25 2-3 P.M.—Ancora Psychiatric Hospital, Hammonton
(Ancora Psychiatric Hospital and AMNJ)

19 **Controversies and Pitfalls in Modern Sex Therapy**
5-6:30 P.M.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

OBSTETRICS/GYNECOLOGY

Mar.

9 **Semmelweis-Waters Ob/Gyn Conference**
10 8 A.M.-5 P.M.—Resorts International
11 Hotel, Atlantic City
(UMDNJ—NJ Medical School, Dept. of Ob/Gyn and Office of Continuing Education and AMNJ)

31 **Contraception Today**
9 A.M.-5 P.M.—Princeton Scanticon Conference Ctr., Princeton
(UMDNJ-Rutgers Medical School and AMNJ)

Apr.

1 **Contraception Today: Improving the Results, Reducing the Concerns**
9 A.M.-12 noon—Princeton Scanticon Conference Ctr., Princeton
(UMDNJ—Rutgers Medical School and AMNJ)

PATHOLOGY

Mar.

1 **Biology of Immune Complexes in Cancer**

8 **Epidemiology of Cancer: An Overview**
4-6 P.M.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

14 **Pathology Grand Rounds**
10:30 A.M.-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

21 **Pathology Slide Seminar/New Procedure Update**
7-9 P.M—Hyatt House, Cherry Hill
(South Jersey Pathology Society and AMNJ)

Apr.

11 **Pathology Grand Rounds**
10:30 A.M.-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

12 **Radio-labeled Antibodies for Cancer Detection and Therapy**
4-6 P.M.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

PEDIATRICS

Mar.

1 **The Mouth and Teeth in Pediatric Practice**
9 A.M.—Freehold Area Hospital
(AMNJ)

19 **Pediatric Lecture Series**
12 noon-1 P.M.—The Mountainside Hospital, Montclair
(The Mountainside Hospital and AMNJ)

21 **Chronic Disorders in Pediatrics:**
22 **New Approaches to Old Problems**
8 A.M.-4 P.M.—Madison Hotel, Convent Station
(Children's Specialized Hospital)

23 **Diagnosis and Management of the Various Forms of Rickets**
8-9:30 A.M.—Overlook Hospital, Summit
(Overlook Hospital and AMNJ)

Apr.

5 **Hematonia and Proteinura in Children**
9 A.M.—Freehold Area Hospital
(AMNJ)

16 **Pediatric Lecture Series**
12 noon-1 P.M.—Mountainside Hospital, Montclair
(Mountainside Hospital and AMNJ)

25 **Pediatric Allergy**
10:30 A.M.-12 noon—St. Mary's Hosptial, Passaic
(St. Mary's Hospital and AMNJ)

RADIOLOGY

Mar.

8 **New Aspects of Obstetrical and Gynecological Ultrasound**
8:30-9:30 A.M.—Saint Barnabas Medical Ctr., Livingston
(New Jersey Institute of Ultrasound in Medicine and AMNJ)

16 **Radiology Meeting**
7:30-10 P.M.—Saint Barnabas Medical Center, Livingston
(Radiological Society of NJ and Radiological Section, AMNJ)

21 **Dinner Meeting**
6:30 P.M.—The Manor, West Orange
(Radiotherapy Section, AMNJ)

Apr.

12 **Invasive Fetal Therapy**
8:30-9:30 P.M.—Saint Barnabas Medical Ctr.
(New Jersey Institute of Ultrasound in Medicine and AMNJ)

18 **Pathogenesis, Diagnosis, and Management of Type II Diabetes**
1-2:30 P.M.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

19 **Radiology Meeting**
7:30-10 P.M.—Saint Barnabas Medical Ctr., Livingston
(Radiological Society of NJ and Diagnostic Radiology Section, AMNJ)

26 **Radiation Therapy: Current Practice and Future Potential**
4-6 P.M.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

218th Annual Meeting
May 2-6, 1984

Wednesday, May 2, 1984
3:30 p.m.—Board of Trustees' Meeting
7:00 p.m.—Officers' Cocktail Reception followed by Dinner

Thursday, May 3, 1984
9:00 a.m.—Registration Opens
2:00 p.m.—House of Delegates
4:00 p.m.—Reference Committees (Three Reference Committee Meetings)

Friday, May 4, 1984
7:30 a.m.—Registration Opens
9:00 a.m.—House of Delegates (election)
9:00 a.m.—Message Center, and Scientific, Informational, and Insurance Exhibits Open
12:00 noon—Golden Merit Award Ceremony followed by Reception
2:30 p.m.—Reference Committees (Three Reference Committee Meetings)
5:00 p.m.—JEMPAC Political Forum
5:45 p.m.—JEMPAC Wine & Cheese Reception

Saturday, May 5, 1984
8:00 a.m.—Registration Opens
9:00 a.m.—Message Center, and Scientific, Informational, and Insurance Exhibits Open
9:00 a.m.—Scientific Sessions
12:00 noon—Luncheons
1:00 p.m.—Scientific Sessions
6:30 p.m.—Inaugural Reception followed by Inaugural Dinner

Sunday, May 6, 1984
6:30 a.m.—County Society Breakfast Caucuses
8:00 a.m.—Registration Opens
9:00 a.m.—Message Center, and Scientific, Informational, and Insurance Exhibits Open
9:00 a.m.—House of Delegates
3:00 p.m.—Board of Trustees' Meeting

SURGERY

Mar.

4 **Use of Appropriate Antibiotics in Surgery**
10:30 A.M.-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

7 **Diagnosis and Surgical Management of Esophageal Reflux and Hiatus Hernia**
10:30 A.M.-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

7 **Surgical Departmental Conference**
14 8:30-10 A.M.—Rutgers Medical School,
21 New Brunswick
28 *(UMDNJ-Rutgers Medical School)*

Apr.

4 **In and Out Surgery**
10:30 A.M.-12 noon—St. Mary's Hospital, Passaic
(AMNJ)

4 **Surgical Departmental Conferences**
11 8:30-10 A.M.—Rutgers Medical School,
18 New Brunswick
25 *(UMDNJ—Rutgers Medical School and AMNJ)*

SURGICAL SPECIALTIES

Mar.

1 **Vascular Surgical Rounds**
8 4-5 P.M.—Rutgers Medical School,
15 New Brunswick
22 *(UMDNJ-Rutgers Medical School)*
29

6 **Surgical Management of Benign and Malignant Disease of the Breast**
7:30 P.M.—Burdette Tomlin Memorial Hospital, Cape May Court House
(AMNJ)

31 **Management of Patients with Low Vision**
8:15 A.M.-4:30 P.M.—Saint Barnabas Medical Center, Livingston
(St. Barnabas Medical Center and AMNJ)

Apr.

5 **Vascular Surgical Rounds**
12 4-5 P.M.—Rutgers Medical School,
19 New Brunswick
26 *(UMDNJ-Rutgers Medical School and AMNJ)*

7 **9th Annual Orthopaedic Symposium**
8 A.M.—UMDNJ-Rutgers Medical School, Newark
(AMNJ)

11 **Yag Laser Use in Ophthalmology**
1-2:30 P.M.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

18 **Biliary Tract Surgery**
10:30 A.M.-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

26 **Glaucoma: A Compendium of Diseases**
8-10 P.M.—Bergen County Medical Society, Hackensack
(NJ Medical Women's Association and AMNJ)

MISCELLANEOUS

Mar.

Clinicolegal Correspondence Course Self-Instruction-Contact Medical Inter-Insurance Exchange of New Jersey
(Medical Inter-Insurance Exchange of NJ and AMNJ)

LETTER TO THE EDITOR

Alternative Treatment to Breast Cancer

November 30, 1983

Dear Doctor Krosnick:

Dr. Greco's recent commentary on the treatment of breast cancer (November 1983) should serve to stimulate not only surgeons, but all physicians, to revaluate their own entrenched views oncerning the conventional management of breast cancer.

The growing body of scientific vidence from centers in France, Italy, anada, and the United States, suggests hat conservative surgery combined with adiotherapy is an acceptable alternative to mastectomy for those patients having a strong motivation for breast preservation. A good summary of such data is found in a newly published text.[1]

Meaningful randomized prospective studies are difficult to obtain in an illness so charged with emotional feelings. A bias is introduced at the onset of such studies since only a small percentage of women with breast cancer will allow themselves to be randomized.

While there are well-known advantages and disadvantages to both conventional and conservative therapy, one cannot help but wonder if women would come forth sooner with earlier, more curable breast cancers if they did not always believe that a mastectomy was mandatory. Any disadvantage of conservative treatment for breast cancer might be offset by the availability of such therapy serving as a stimulus to women to seek earlier treatment, hopefully resulting in a greater number of cures.

For the present, it certainly would seem prudent to keep an open mind to both forms of therapy and to inform patients fully of their alternatives.

Murray H. Seltzer, M.D.

REFERENCE

1. Harris JR, et al.: *Conservative Management of Breast Cancer.* Philadelphia, PA, J.B. Lippincott Co., 1983.

AN ACT OF LOVE

Their own **DENIAL** that a respected colleague could be **IMPAIRED** and/or the "conspiracy of silence" that makes them unwilling to speak out allows the illness of our impaired colleagues to progress, sometimes to a fatal outcome.

"Blowing the whistle" on a suffering colleague is indeed an **ACT OF LOVE!**

Call Us **EARLY**
We can help **CONFIDENTIALLY**
IMPAIRED PHYSICIANS PROGRAM
(609) 896-1766
Hot Line . . . (609) 896-1884

OBITUARIES

Dr. Sidney L. Cohen

Word has been received of the death of Sidney L. Cohen, M.D., an emeritus member of our Essex County component. Born in 1899, Dr. Cohen earned his medical degree from New York Medical College in 1925. A family practitioner, Dr. Cohen was affiliated with Newark Beth Israel Medical Center.

Dr. Paul B. Ferrary

At the age of 74, Paul Bernard Ferrary, M.D., died on November 8, 1983. Dr. Ferrary received his medical degree from Georgetown University School of Medicine, Washington, D.C., in 1933. A member of our Passaic County component and of the American Medical Association, Dr. Ferrary was affiliated with St. Joseph Hospital and Medical Center, Paterson. A diabetologist, Dr. Ferrary practiced in Totowa during his lengthy career.

Dr. Perry O. Hall

At the grand age of 88, Perry O. Hall, M.D., died on November 17, 1983. Dr. Hall was a graduate of the University of Pennsylvania School of Medicine in 1920. An obstetrician-gynecologist, Dr. Hall was affiliated with Margaret Hague Maternity Hospital, Jersey City, West Hudson Hospital, Kearny, Elizabeth General Medical Center, and Jersey City Medical Center. In 1970, Dr. Hall was a recipient of MSNJ's Golden Merit Award for 50 years of medical service. He retired from practice in 1973. Dr. Hall was a retired member of our Hudson County component and a member of the American Medical Association.

Dr. Harold E. James

We have learned of the death of Harold E. James, M.D., a member of our Essex County component. Born in 1918, Dr. James received his medi degree from New York Medical Coll in 1961. A surgeon, Dr. James was filiated with three Newark hospit Saint James Hospital, St. Micha Medical Center, and Presbyterian H pital.

Dr. Sol S. Winsten

Sol Stephen Winsten, M.D., a me ber of our Essex County compone died on November 16, 1983. Born 1909, Dr. Winsten earned his medi degree at the University of Berne, Swi erland, in 1939. A psychiatrist, D Winsten was affiliated with Muhlenbe Hospital, Plainfield, St. Michael's Me cal Center, Newark, and John E. Ru nells Hospital of Union Coun Berkeley Heights. Dr. Winsten was member of the American Medical A sociation and a Diplomate of the Ame can Board of Psychiatry and Neurolog

BOOK REVIEWS

Color Atlas of Life Before Birth

Marjorie A. England. Chicago, IL, Year-book Medical Publishers, 1983. Pp. 216.

This book actually represents an atlas of embryology which is a welcome aid to the medical student as well as to the specialist preparing for his boards. The physical aspect of the book is outstanding; the binding is sturdy, the paper is glossy and of good quality, the print is clear and easy to read, and the color reproductions are superb. The author is an anatomist at the distinguished University of Leicester, England, and should be congratulated for the completion of this most instructive book which deals with a difficult subject.

The contents deal with the development of the fetus from the moment of conception until birth and the book is profusely illustrated. The pictures are well marked with numbers which explain the names of the developing organs. New are the illustrations of fetal ultrasonograms as well as the x-ray pictures in utero. Each organ is not only depicted macroscopically but the normal histology of each organ is included.

The illustrations of the placenta and the fetal membranes are likewise remarkable and afford an excellent insight as to the happenings before birth.

It should be emphasized that this book represents only the normal embryology; therefore abnormal developments, such as failure of closure of ductus arteriosus, or failure of fusions of the Müllerian ducts, or anencephaly, are not depicted; for those the student should refer to the usual textbooks of embryology, e.g. Arey.

The book should be extremely valuable to obstetricians, internists, and urologists, and, last but not least, to forensic physicians since it will give an exact picture of the fetus during each month of development. The book is highly recommended.

Werner Steinberg, M.D.

Coronary Artery Disease in Infants and Children

Henry N. Neufeld, M.D., and Adam Schneeweiss, M.D. Philadelphia, PA, Lea & Febiger, 1983. Pp. 189.

The foreword states, "A new outlook on coronary diseases in adults postulates that the disease may have its origins in infancy and childhood; therefore, it is important that physicians have a clear understanding of disease in children." It is in the meeting of this objective that the book fails. The authors, however, have succeeded in putting together in readable form most of the known information about congenital anomalies of the coronary arteries. A lesser amount of information regarding acquired diseases of the coronary arteries also is included. No new ground is broken here, but such a review of the literature is valuable.

Since the title of the book implies a discussion of coronary artery disease in childhood, it is regrettable that the authors have elected to omit a discussion of the current controversies regarding diet in childhood and its implications for the future development of arteriosclerosis. Such a discussion would have added greatly to the usefulness of an otherwise fine book.

The range of interest for the book will be quite limited, mainly due to its concentration on anatomic variations of the coronary system. However, it will provide a valuable resource to pediatric cardiologists, pediatric and adult cardiovascular surgeons, and a few interested adult cardiologists.

Jay Eldredge, M.D.
Deborah Heart and Lung Center

Current Emergency Diagnosis and Treatment

John Mills, Mary T. Ho, Donald D. Trunkey. Los Altos, CA, Lange Medical Publications, 1983. Pp. 738. ($24)

This 738-page book is the finest text and reference book concerning emergency medicine that I have read in the many years that I have been involved in emergency medicine. It covers every medical emergency that physicians, whether in or out of the hospital emergency department, may come up against.

Every chapter includes a narrative portion, and every subject is covered with tables, diagrams, and radiograms illustrating the emergency where applicable. Every page in the book is utilized including the covers: the inside front cover lists drugs commonly used intravenously in emergencies, and the back cover shows the composition of commonly used intravenous solutions.

The book deals with medical emergencies, and includes the design, operation, and staffing of the hospital emergency department, the management of mass casualties, and emergency care and the law. In addition, there is a special illuminating chapter on emergency procedures.

This book should be in every hospital emergency department and used as a text in the hospital or reference at home by the physician.

Jack R. Karel, M.D.

Primary Prevention of Coronary Heart Disease: A Practical Guide for the Clinician

Richard N. Podell, M.D., and Michael M. Stewart, M.D., (eds). Menlo Park, CA, Addison-Wesley Publishing Company, 1983. Pp. 340.

Primary Prevention of Coronary Heart Disease is a guide designed for the physician, in focusing on the traditional cardiac risk factors: smoking, hypertension, hyperlipidemia, diabetes mellitus, obesity, Type A behavior, and lack of exercise.

Each chapter starts with a brief overview for the reader to establish summary thoughts on the specific risk factor and then proceeds with a clear and understandable review of the current scientific issues around the risk factor, ending with advice to be given the patient on primary prevention.

The subjects discussed have annotated bibliographies, figures, charts, tables, and appendices. Also, given in each chapter are names and addresses of free sources of health-care information and patient educational materials pertinent to coronary heart disease.

This guide can find some use in the hands of health-care personnel as a supplement to other standard textbooks on heart disease.

Harry M. Poppick, M.D.

The Youngest Science

Lewis Thomas, M.D. New York, NY, Viking Press, 1983. ($14.75)

Thomas is an academician, scientist, researcher, and chancellor, but primarily a physician who understands medicine and its ways. Although the format of this book is autobiographical, it serves as an overview of medical practice in the 20th century—when medicine was changing from an art to a science. Thomas went to Princeton and Harvard, but his observations parallel that of any other medical student in the 1930s, 1940s, and 1950s.

Thomas speaks of touching as being the most effective act of physicians ("The doctor's oldest skill in trade was to place his hands on the patient."), and decries the mechanizations and aloofness of modern practice ("Medicine is no longer the laying on of hands, it is more like the reading of signals from machines."). He stresses that the new technologies leave little time for talking with patients and states that often their longest and most personal conversations are "discussions of finances and insurance, engaged in by personnel trained in accountancy, whose scientific instruments are the computers." He calls for the preservation of the uniquely subtle, personal relationship between doctor and patient: "To do it right has never been easy; it takes the best of doctors, the best of friends."

Thomas picks neurology as the most fascinating of all fields of medicine, and his chapter on that subject explains why. It was his early interest in this field that made him the superb scientist he is; would that every physician had his enthusiasm for research! He feels "the key to a long, contented life in the laboratory is to have a chronic insoluble problem and keep working at it." His comparison of the human mind with artificial intelligence (the computer) is fascinating—he admires the latter, but respects the former and acknowledges that he does not understand it: "My own mind, fallible, error-prone, forgetful, unpredictable, and ungovernable, is way over my head."

Thomas traces his rise up the lad of academic success—from a naval u of the Rockefeller Institute Hospital Guam and Okinawa in 1942, to the N tional Institutes of Health in Bethes to Johns Hopkins (pediatrics), to Tul (microbiology and immunology), to University of Minnesota (pediatrics a medicine), to New York University C lege of Medicine (pathology), Bellevue (medicine), to being a meml of the New York City Board of Heal He took a sabbatical leave at the Univ sity of Cambridge to work on placenta. He became the dean of t medical schools (New York Univers and Yale), and finally reached his pinn cle as chancellor of the Memorial Slo Kettering Cancer Center.

He is a skillful writer. In the chapt "Illness," he describes vividly how d ficult it is for a doctor to be a patie His glimpses into his inner self (l colon, his mesenteric vessels, and h knee joint) are vivid and told with subtle sense of humor. Thomas co cludes that his existence is not in t midst of his bodily parts, but perha "an assemblage of electromagnetic pa ticles" beyond his management, runni itself.

The appendix is full of "some iter of verse" which added to his incon during internship and residency. Th first stanza of "Millennium" should l enough to stimulate you to read the re of the poem, and, in fact, the who book, which I am sure will become classic: "It will be soft, the sound th we will hear/ When we have reached th end of time and light./ A quiet, fin noise within the air/ Before we are r turned into the night."

John S. Madara, M.D

NFORMATION FOR AUTHORS

The Journal, the official organ of the Medical Society of New Jersey, is published monthly under the direction of the Committee on Publication. The goals of *The Journal* are educational and informational. All material published in *The Journal* is copyrighted by the Medical Society of New Jersey.

ONTENT

The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports based on unusual clinical experiences; review articles; clinical notes, succinct items on some aspect or new observation or technique of a case experience; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update, and an opinion column. Editorials are prepared by the Editor and by guest contributors on timely and relevant subjects; editorials are the responsibility of the author. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the Editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of contribution should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made in New Jersey.

ASSIGNMENT OF COPYRIGHT

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978), a transmittal letter or a separate statement accompanying material offered to *The Journal* of the Medical Society of New Jersey must contain the following language and must be signed by all authors:

"In consideration of *The Journal* of the Medical Society of New Jersey taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *The Journal*, MSNJ."

SPECIFICATIONS

Submit two **manuscripts** that must be typewritten and double-spaced on 8-1/2" by 11" paper. This material is for the exclusive use of *The Journal* and will not be published elsewhere except in abstract form or with the consent of the Committee on Publication. Statistical methods used in articles should be identified. Acknowledgments will be made only for specific preparation of an essential part of the manuscript.

Authors are asked to seek clarity, accuracy, and originality; attention to details of grammar, spelling, and typing are important.

The **title page** should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

The author should submit a 50-word **abstract** to be used at the beginning of the article.

Tables must be typewritten and double-spaced on separate 8-1/2" by 11" sheets, with a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source; written permission for republication from the original publisher must be submitted. The cost of color photographs must be borne by the author.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

The **summary** of the article should not exceed 250 words; it should contain only essential facts.

References should not exceed 35 citations except in review articles, and should be cited consecutively in the text by numbers in parentheses at the end of the sentence. The reference list should be typewritten and double-spaced on separate 8-1/2" by 11" sheets in the numerical order in which they are first cited in the text. The style of reference is that of *Index Medicus:*

1. Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis.* New York, NY, McGraw-Hill, 1969, Pp. 42-48.

PUBLICATION POLICY

Receipt of each manuscript will be acknowledged and a copy delivered to the Editor who refers the paper to one or more members of the Editorial Board. The final decision is reserved for the Editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. Galley proofs will be submitted to the author for correction of typographical errors.

REPRINT ORDERS

Reprints may be ordered after the author is notified that the article has been selected for a specific issue of JMSNJ. A check for the cost of reprints including remake charge if order is received after due date must accompany the order.

COMMUNICATIONS

All communications should be sent to the Editor, *The Journal*, MSNJ, 2 Princess Road, Lawrenceville, NJ 08648.

CLASSIFIED ADVERTISEMENTS

ANESTHESIOLOGIST—Board certified, experienced anesthesiologist seeks position in Central or South Jersey. Broad clinical experience in all phases of Anesthesiology. Small hospital preferred. Resume and details on request. Reply to Mainland Anesthesia P.A., 52 East New York Avenue, Somers Point, NJ 08244. Call (609) 927-7782.

DIAGNOSTIC RADIOLOGIST—Board certified, trained in general diagnosis, nuclear medicine, special procedures, C.T. and ultrasound. Available full or part-time; group practice or hospital based; North or Central New Jersey. Can also provide mobile ultrasound and office consultation. Reply to Box No. 63, JMSNJ.

GASTROENTEROLOGIST—University trained. Trained in all procedures including ERCP, laparoscopy, sclerotherapy. Seeks practice opportunities in New Jersey beginning July 1984. Contact Dr. H.L. Kirschebaum, 780 Woolley Avenue, Staten Island, NY 10314.

GENERAL PRACTITIONER—Desires industrial, pharmaceutical or similar position. Semi-retired, age 55, (201) 545-4339.

GENERAL SURGEON—Board certified, wishes to join another surgeon or a group in area of Monmouth County or adjoining counties. If interested please contact Dr. Hasan (201) 972-1584.

INTERNAL MEDICINE—Board eligible, general internist with extensive emergency room experience seeking group practice of internal medicine or emergency room position. Northern New Jersey area. Available July 1984. Please call (212) 645-4616, Steven Wolinsky, M.D. Curriculum vitae and references available upon request.

INTERNIST—Board eligible, looking for an opportunity to join group practice in North or Central New Jersey starting July 1984. Please call (201) 533-1982 or contact Dr. Bardmesser, 145 Sycamore Avenue, Livingston, NJ 07039.

OB/GYN—Board certified, 35, experienced. Wants to relocate. Solo, group or partnership. Available immediately. Write Box No. 66, JMSNJ.

OPHTHALMOLOGIST—Board eligible, July 1984, Board certified Pediatrics (1982), age 29, desires partnership or group. Available July 1984. Write Box No. 65, JMSNJ.

PHYSICIAN—Semi-retired, age 57, seeking part time or full time position. Preferable industrial clinic. Telephone (201) 224-5252.

NEEDED ASSOCIATE—Pediatrician, board certified; seeks associate, board certified/eligible, to join well established practice. Excellent opportunity. Northern New Jersey near New York City. Write Box No. 40, JMSNJ.

NEEDED INTERNIST—Board certified/board eligible. Must have had training in cardiology, gastroenterology and endoscopy for Associate position in busy general practice Northern New Jersey suburban setting. Submit resume to Box No. 56, JMSNJ.

NEEDED OB/GYN—To join solo practice in South Jersey Shore area. Growing area. One hour from Philadelphia. Write Box No. 42, JMSNJ.

NEEDED PHYSICIANS—Family Practice in Central Jersey needs doctor with malpractice insurance to work occasional Saturdays and weekdays or week nights. (201) 722-2522.

NEEDED PHYSICIANS—New Free Standing Emergency Clinic in Central Jersey needs Medical Director plus full and part-time physicians. Write P.O. Box 6485, Bridgewater, NJ 08807.

NEEDED PRIMARY CARE PHYSICIANS—Private fee-for-service practice in new, fully equipped suburban offices. All personnel supplies, and management services provided. This is an excellent opportunity for physicians with a good "bedside" manner interested in developing a lucrative practice and still desiring time for the pursuit of happiness. Reply to: Neighborhood Doctor Corporation, 901 Long Beach Blvd., Ship Bottom, NJ 08008.

NEEDED RADIOLOGIST—Part time, 2 mornings per week. Ocean County. Prefer competent retired person. Write Box No. 62, JMSNJ.

ALLERGY PRACTICE—Allergist certified or board eligible for Purchase of very desirable Practice, child and adult. Central NJ. Write Box No. 47, JMSNJ.

PRACTICE FOR SALE—ENT, established 16 years. Fully equipped modern office. Excellent location. Terms available. Deceased-immediate. Vineland, NJ. Close to Atlantic City and Philadelphia. (609) 692-2536.

PRACTICE FOR SALE—OB/GYN. Immediately in Northern Monmouth County, near two accredited hospitals in appealing residential community. Will introduce. (201) 264-7763.

PRACTICE FOR SALE—Pediatrics. Lo established practice, ½ block from hospi Property and equipment. Located in Midd sex County. Will introduce. Write Box N 64, JMSNJ.

PRACTICE FOR SALE OR RENT—Fam Practice, for sale or rent office and equipm near a 550 bed teaching hospital in Mo mouth County. Call after 6 P.M. (20 681-2566.

FOR SALE OR RENT—Fully equipped a furnished medical office building includi small medical practice, ECG, x-ray machin therapeutic ultrasound, Pulmonor. Good l cation. Kearny. Call after 8 P.M. (20 746-1709.

FOR SALE—OFFICE SPACE. Rosel modern 2,400 square feet, 6 treatment roor and 4 consultation rooms. On-site parkin Warinanco Medical Building. Phone (20 687-0102.

OFFICE SPACE SHARE NEEDED—Boa certified internist desires office spaces Camden County (Cherry Hill, Haddonfie area) or Salem County area. Call Dr. Ch (513) 475-4368.

OFFICE FOR SHARE—Highland Park, 9(square feet office space, fully equipped. Ne hospital, minimal rent. $250.00 per mont including utility and equipment. For detai call (201) 545-2045.

OFFICE SPACE TO SHARE—Morristow central location. Near hospital, full equipped, newly decorated. All utilities i cluded. Ample parking available. Near publ transportation. Available immediately. (20 267-2555.

SHARE OFFICE—Ridgewood, near Valle Hospital, Prime medical space, new building large parking lot, easily accessible on mai road. Call (201) 652-6060.

OFFICE SPACE TO SHARE—Westfield central location. Near hospital, full equipped, attractively decorated. All utilitie included. Ample parking available. Near pub lic transportation. Available immediately (201) 267-2555.

OFFICE FOR RENT—Bergen County Ridgefield, NJ. Office for rent, 700 square feet. Call (201) 833-0117.

RATE INFORMATION FOR MEMBERS: $5.00 per insertion up to 25 words; 10 cents each additional word. Payable in advance. **WORD COUNT:** Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one word, and "Write Box No. 000, c/o JMSNJ" as six words. **COPY DEADLINE:** Fifth of preceding month.

CLASSIFIED ADVERTISEMENTS

FFICE SPACE—For immediate occupancy w, modern, energy efficient rental 500 to 00 square feet available from $5 per foot. ,000 residents within three mile radius. ose to Philadelphia, Atlantic City in Cen- l Jersey shore area. Internists and special- s needed. Ideal for main/satellite office. ll (201) 350-1008.

FFICE SPACE—Edison, 1,214 square feet, oom, bathroom, carpeted, near all high- ys and hospitals, on-site parking. Avail- le immediately. Call Dr. Bronstein (201) 3-8000.

FFICE FOR RENT—Edison, 1,300 square t, new building, 172 Amboy Avenue. mple parking, no steps. Near Perth Amboy d JFK hospitals. Call (201) 442-4444.

OFFICE SPACE—Southern NJ, Gloucester Township, Camden County. Office suite in new medical building for rent; 1000 or 2000 square foot suites available. Located in rapidly growing, highly desirable area, near several large hospitals. Ideal for family practice or specialist. Building to be completed late 1984. Call Dr. Ribatsky (609) 227-2221.

OFFICE FOR RENT OR SHARE—Hazlet, Holmdel area, 600 to 1500 square feet, furnished, ample parking. Close to hospital. Call (201) 264-7763.

OFFICE SPACE—Moorestown, NJ. Victoria Medical Arts Building. Renting custom medical offices in new building. Ideal for radiologist, orthopedist, urologist, general surgeon, industrial physician. Excellent location and parking. Call (609) 235-2651.

OFFICE SPACE—North Haledon. Two side by side 750 square feet suites available in professional building close to Paterson General Hospital. Immediate occupancy. Will alter to suit or Purchase the entire 3000 square foot building. Free basement storage. Call (201) 427-7500.

OFFICE FOR RENT—Professional office for rent, approximately 710 square feet near Dover General Hospital. Near Routes 80 and 46. Morris County, NJ. Telephone (201) 366-2557.

FOR SALE—Boat. 1982 Sea Ray Sedan 26 foot, all extras. Call (201) 864-7172.

ATE INFORMATION FOR MEMBERS: $5.00 per insertion up to 25 words; 10 cents each additional word. Payable in advance. **WORD OUNT:** Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated ords. Count name and address as five words, telephone number as one word, and "Write Box No. 000, c/o JMSNJ" as six words. **OPY DEADLINE:** Fifth of preceding month.

NEW YORK FERTILITY RESEARCH FOUNDATION, INC.

For the Investigation of Problems of Human Infertility

The Foundation provides a complete diagnostic and consultation service for infertile couples. Investigations are conducted by well-known specialists in conjunction with consultants in the various fields of medicine related to infertility.

The Foundation is supported by an in-house modern laboratory equipped to do most tests required for diagnosis and treatment. Literature on request.

1430 Second Avenue, Suite 103
New York, N.Y. 10021
Phone: (212) 744-5500

Personnel

See Page 160

OFFICE SUITE

Millburn Ave., Maplewood-small prof. bldg. 1 suite avail. Approx. 1000 sq. ft. $1,200.00 mth.—set for M.D., etc. 3 trmt. rms., sml. kitchen, x-ray rm., lav., waiting rm., Nurse station & storage—1st flr.

Call L.L. Leifer, Esq., Days (201) 763-8555, Eve. (201) 325-8630.

Need A Temporary Physician?

CompHealth treats your practice as if it were our own during: vacations, CMEs, recruiting, clinic start-up or other absences.

Want Free Time While You Practice Medicine?

Join CompHealth's Locum Tenens Physician Group.

★

For further information about temporary coverage or locum tenens practice opportunities, call:

CompHealth

A Physician Group

WILSON ROSS, Regional Administrator
114 Centennial Avenue
Sewickley, PA 15143
Telephone: 412/741-3310

EMERGENCY PHYSICIAN ASSOCIATES, P.A.

From the desk of
JAMES E. GEORGE, M.D., J.D.
President

To: Career Oriented Emergency Physicians

Re: A Rewarding Career in Emergency Medicine

Can you accept the challenge of joining a progressive, growing, professional emergency physician group? If so, send your C.V. in confidence to: James E. George, M.D., J.D., **Emergency Physician Associates, P.A.**, PO Box 298, Woodbury, New Jersey 08096 or call (609) 848-3817.

E.P.A. Offers:

- ☑ Competitive income
- ☑ Malpractice insurance
- ☑ Flexible schedule
- ☑ CME credits
- ☑ Urban and rural settings
- ☑ Close proximities to New York, Philadelphia and the New Jersey seashore
- ☑ E.D. patient volumes from 10,000 to 65,000
- ☑ ACLS-ATLS certification

Emergency Physician Associates, P.A.; prefers dedicated physicians with board eligibility in emergency medicine, family practice, internal medicine or surgery with prior emergency department experience.

Call or write to us for an **E.P.A.** application that will start you on your way to a rewarding career in emergency medicine.

Can You Accept the Challenge?

PHYSICIANS

U.S. NAVY MEDICAL DEPARTMENT
An Equal Opportunity Employer

Positions are presently available in the following areas:

- General surgery & Surgical Specialties
- Ortho Surgery
- Pathology
- Anesthesiology
- Neurology
- Family Practice
- Other Specialties
- Preventive/Occupational Medicine

NAVY MEDICINE

- Provides the qualified physician with the opportunities to become a member of global health care system.
- Is practiced in excellent medical facilities in conjunction with a highly professional staff of support personnel.
- Allows the physician the advantage of experiencing all aspects of medicine including teaching, research, administration and graduate medical education without the associated career disruption.
- Provides the physician with an officer's commission with attendant benefits and privileges.

Basic qualifications for a commission as a NAVY physician include U.S. citizenship and excellent professional references.

For a preliminary review of your qualifications, send your curriculum vitae to:

MEDICAL PROGRAMS, CODE MD20
NAVY RECRUITING DISTRICT
128 NORTH BROAD STREET
PHILADELPHIA, PA 19102
(COLLECT) (215) 568-2042
ATTN: LT PAT DAY

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY
MARCH 1984



The Library
Acquisitions Division
San Francisco

PSYCHOLOGICAL EFFECTS OF RHINOPLASTY

Send this coupon for no-obligation information of the savings under the Medical Society of New Jersey Endorsed Insurance Plans

Check this list against your coverages . . . .

- ☐ $5000 Monthly Guaranteed Convertible Accident and Health
- ☐ $10,000 Monthly Practice Overhead Expense
- ☐ $1,250,000 Term Life Insurance
- ☐ $500 Deductible COMPREHENSIVE MILLION-DOLLAR MAJOR MEDICAL PLAN—No other coverage needed—Issuable to Age 69
- ☐ $15,000 Deductible MILLION-DOLLAR UMBRELLA MAJOR MEDICAL PLAN for holders of Blue Cross and other Major Medical Plans—Issuable to Age 69
- ☐ $100-a-day Hospital Income Policy
- ☐ $200,000 High Limit Accident Plan
- ☐ Keogh and Corporate Plan NOW! $15,000 KEOGH

E. & W. Blanksteen Agency, Inc.

E. & W. Blanksteen
75 Montgomery St.,
Jersey City, N.J. 07302
(201) 333-4340
or (800) 742-2849

Name: _____

Address: _____

_____

Tel. No. _____

Best Time To Call _____

SOME COMPANIES OFFER YOU AN OXYGEN TANK...

HoMed OFFERS YOU OUR ENTIRE AIR CORPS



"The essence of any fine Respiratory Therapy Program, is the quality of care and diversity of systems. That's why I insist our therapists be familiar with the most recent innovations and pay careful attention to proper procedures." — June Walker, Dir. of Respiratory Services

- Liquid Oxygen
- O_2 Cylinders
- Concentrators
- Portables
- Free Disposable Supplies
- Delivery and Initial Medication
- Same Day Set-up
- Monthly Visits by Our Therapists
- Progress Reports to the Physician
- Instruction in Chest Physicial Therapy & Postural Drainage



JUNE WALKER
Director of Respiratory Services

HoMED...the Home Health Care Company

Serving the Greater Metropolitan Area

CALL TOLL FREE - NORTHERN N.J. (800) 452-9777 SOUTHERN N.J. (800) 392-6936
OUTSIDE NEW JERSEY CALL COLLECT - (201) 227-1800

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

Officers and Trustees

PRESIDENT
Alexander D. Kovacs, M.D. (Union) ..... Scotch Plains
PRESIDENT-ELECT
Frank Y. Watson, M.D. (Essex) ..... Glen Ridge
FIRST VICE-PRESIDENT
Ralph J. Fioretti, M.D. (Bergen) ..... Rochelle Park
SECOND VICE-PRESIDENT
Edward A. Schauer, M.D. (Monmouth) ..... Farmingdale
IMMEDIATE PAST-PRESIDENT
Howard D. Slobodien, M.D. (Middlesex) ..... Metuchen
SECRETARY
Arthur Bernstein, M.D. (Essex) ..... South Orange
TREASURER
Paul J. Hirsch, M.D. (Somerset) ..... Bridgewater

Trustees

Douglas M. Costabile, M.D., *Chairman* (1984) (Union) ..... Murray Hill
Frank Campo, M.D. (1984) (Mercer) ..... Trenton
Harry M. Carnes, M.D. (1985) (Camden) ..... Audubon
Joel S. Cherashore, M.D. (1986) (Essex) ..... Nutley
John J. Crosby, Jr., M.D. (1984) ..... Jersey City
Palma E. Formica, M.D. (1984) (Middlesex) ..... New Brunswick
Harry W. Fullerton, Jr., M.D. (1985) (Salem) ..... Carney's Point
Frank Gingerelli, M.D. (1986) (Bergen) ..... Hackensack
William Greifinger, M.D. (1984) (Essex) ..... Belleville
John P. Kengeter, M.D. (1984) (Ocean) ..... Toms River
Edwin W. Messey, M.D. (1985) (Burlington) ..... Willingboro
Myles C. Morrison, Jr., M.D. (1985) (Morris) ..... Morristown
John J. Pastore, M.D. (1986) (Cumberland) ..... Vineland
Michael R. Ramundo, M.D. (1984) (Passaic) ..... Clifton

Councilors

FIRST DISTRICT
(Essex, Morris, Union, and Warren Counties)
Edward M. Coe, M.D. (1984) ..... Cranford
SECOND DISTRICT
(Bergen, Hudson, Passaic, and Sussex Counties)
Robert A. Weinstein, M.D. (1986) ..... Newton
THIRD DISTRICT
(Hunterdon, Mercer, Middlesex, and Somerset Counties)
Albert F. Moriconi, M.D. (1985) ..... Trenton
FOURTH DISTRICT
(Burlington, Camden, Monmouth, and Ocean Counties)
Frederiek W. Durham, M.D. (1984) ..... Haddonfield
FIFTH DISTRICT
(Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties)
Paul H. Steel, M.D. (1986) ..... Atlantic City

AMA Delegates

William J. D'Elia, M.D., *Chairman* (1985) ..... Spring Lake
Alfred A. Alessi, M.D. (1984) ..... Hackensack
Frederick W. Durham, M.D. (1984) ..... Haddonfield
Palma E. Formica, M.D. (1984) ..... New Brunswick
Karl T. Franzoni, M.D. (1984) ..... Trenton
John S. Madara, M.D. (1984) ..... Salem
Henry J. Mineur, M.D. (1984) ..... Cranford
Myles C. Morrison, Jr., M.D. (1985) ..... Morristown
Howard D. Slobodien, M.D. (1985) ..... Metuchen

AMA Trustee

James S. Todd, M.D. (Ridgewood) ..... Bergen

March 1984

Publication Committee

Paul J. Hirsch, M.D., *Chairman*
Dirck L. Brendlinger, M.D.
Frederick B. Cohen, M.D.
A. Olusegun Fayemi, M.D.
Robert M. MacMillan, M.D.
Leon G. Smith, M.D.
La Verne Fioretti

Editor

Arthur Krosnick, M.D.

Managing Editor

Geraldine R. Hutner

Assistant Managing Editor

Dorothy J. Griffith

Advertising Manager

E. Elizabeth Cookson

Executive Director

Vincent A. Maressa

Executive Director Emeritus

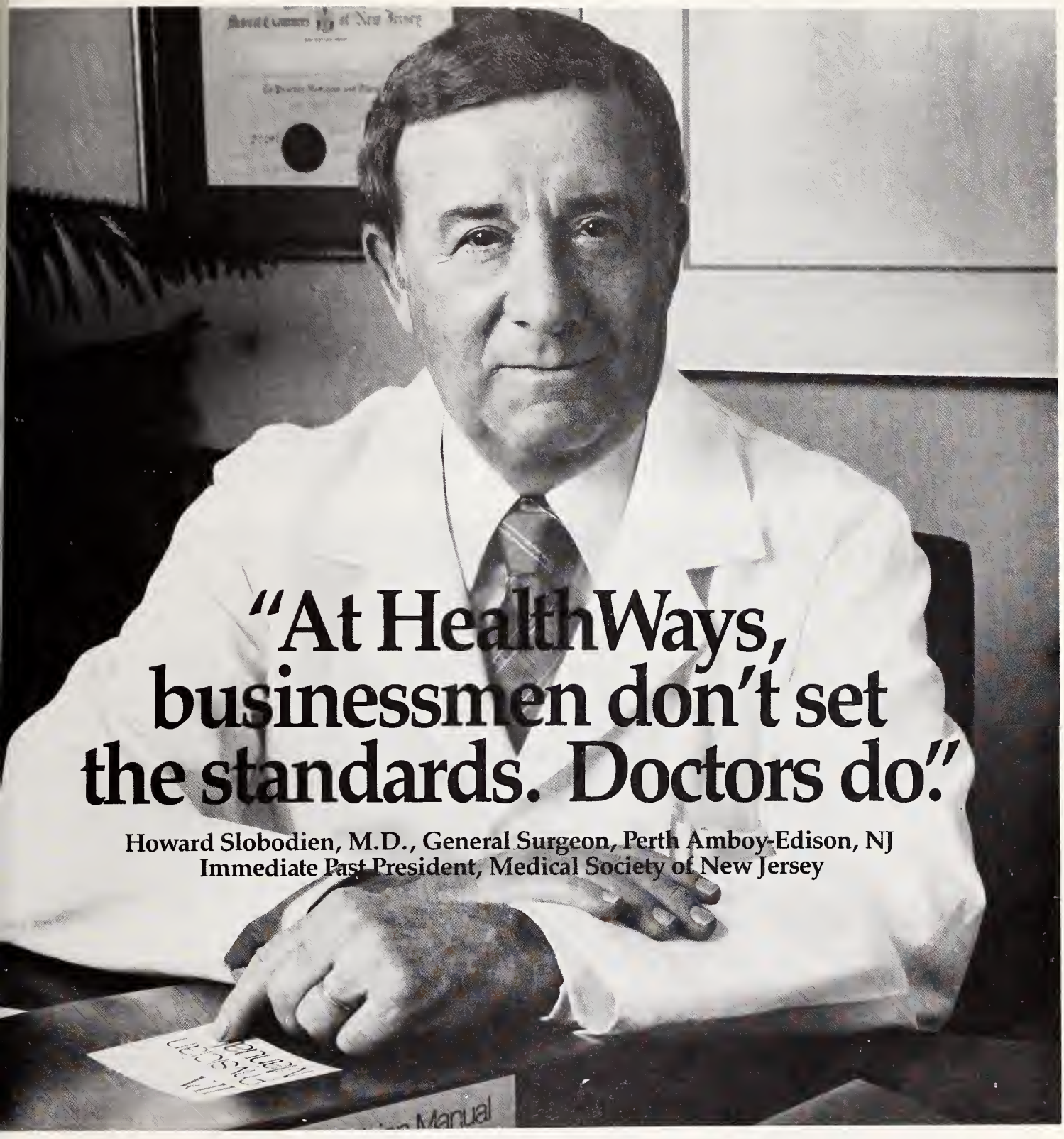
Richard I. Nevin

Editorial Board

Jerome Abrams, M.D. (Obstet/Gynecol)
Joseph Alpert, M.D. (Vasc Surg)
Harold Arlen, M.D. (Otolaryngol)
Alfonse Cinotti, M.D. (Ophthalmol)
Robert Dodelson, M.D. (Nephrol)
Wm. A. Dwyer, Jr., M.D. (Surg)
Norman H. Ertel, M.D. (Int Med/Endocrinol)
Daniel P. Greenfield, M.D. (Psychiat)
Christine E. Haycock, M.D. (Sports Med)
Monroe S. Karetzky, M.D. (Pulmon Med)
Avrum L. Katcher, M.D. (Pediatr)
Stanley C. Leonberg, Jr., M.D. (Neurol)
Joel D. Levinson, M.D. (Gastroenterol)
Henry R. Liss, M.D. (Neurosurg)
Geobel A. Marin, M.D. (Int Med/Gastroenterol)
Donald G. McKaba, M.D. (Allergy)
Robby Meijer, M.D. (Plas Surg)
Frank T. Padberg, Jr., M.D. (Surg)
Christopher A. Papa, M.D. (Dermatol)
Norman Riegel, M.D. (Book Review)
Edwin L. Rothfield, M.D. (Cardiol)
Benjamin F. Rush, Jr., M.D. (Surg)
Morris H. Saffron, M.D. (Med His)
Mark M. Singer, M.D. (Int Med/Endocrinol)
Sheldon D. Solomon, M.D. (Rheum)
Lloyd N. Spindell, M.D. (Radiol)
A. Arthur Sugerman, M.D. (Psychiat)
Stephen F. Wang, M.D. (Pediatr)
Edwin S. Wilson, M.D. (Radiol)
Louis S. Zeiger, M.D. (Nucl Med)
Robert B. Zufall, M.D. (Urol)

The Journal of the Medical Society of New Jersey (ISSN-0025-7524) is published monthly (since 1904) except semimonthly in July (13 issues), under direction of the Committee on Publication, by the Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648. Printed in East Stroudsburg, PA, by the Hughes Printing Co. Whole number of issues 960. Member's subscription ($10) is included in Society dues. Rates for nonmembers, $20; outside USA add $7.50 for postage. Single copies, $2. Address communications to *The Journal* MSNJ, Two Princess Road, Lawrenceville, NJ 08648, (609) 896-1766. Second-class postage paid at Trenton, NJ, and additional entry office.

Copyright 1984 by the Medical Society of New Jersey.



"At HealthWays, businessmen don't set the standards. Doctors do."

Howard Slobodien, M.D., General Surgeon, Perth Amboy-Edison, NJ
Immediate Past President, Medical Society of New Jersey

"Before I joined my local IPA (Individual Practice Association), which is a participant in HealthWays, I needed some basic questions answered.

Question 1: With cost containment so critical to the HealthWays' philosophy, will I have to follow guidelines set up by an accountant?

Answer: No. All the medical checks and balances in HealthWays are checked and balanced by doctors. Colleagues all. Their guidelines are far from arbitrary. They not only make for good medicine, they make good sense.

Question 2: Can I maintain the high quality of my practice without worrying about driving patients to the poorhouse?

Answer: With HealthWays' unique reimbursement policy —I can and do. They even cover routine check-ups, and you know their importance.

Question 3: Are there any other practical advantages for the physician?

Answer: Yes. Several. Since all bills are directed to HealthWays, there are no bad debts with my HealthWays patients. There are also other benefits which you should check out for yourself."

For answers to all your questions and full information, call Jon Marsicano, M.D., Vice President, Medical Affairs, at 201-636-6200 or 609-394-1995.

HealthWays
THE WAY TO BETTER HEALTH CARE.

© 1983 HealthWays Inc.

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY
MARCH 1984

FEATURES

167 Membership Newsletter
175 Professional Liability Commentary
180 Editorials
185 Hospital Governing Boards

CONTRIBUTIONS

187 **Psychological Effects of Rhinoplasty**
A.I. Glasgold, M.D., and S.B. Horowitz, Ph.D., New Brunswick
190 **Radionuclide Testicular Scanning**
J.L. McCormack, M.D., Long Branch
197 **Evaluation of the Suicidal Adolescent Patient Admitted to an Urban Hospital**
S. Pierog, M.D., and A. Hill, Ph.D., Jersey City
205 **A Method of Abdominal Wound Closure**
I.D. Samson, M.D., J. Schulman, M.D., J.C. Sabo, M.D., W.M. Schulman, M.D., L.W. Silvers, M.D., Lakewood
211 **Case Report: Aneurysm of the Descending Thoracic Aorta**
S.K. Agarwal, M.D., J.I. Haft, M.D., M. Bachik, M.D., Newark
217 **Case Report: Radiographic Findings in Pseudomembranous Colitis**
R.S. Altin, M.D., Long Branch
222 **Commentary: Whatever Happened to Benign Neglect?**
M.A. Nevins, M.D., Woodcliff Lake
229 **Commentary: The Conroy Case**
H. Rothberg, M.D., Princeton

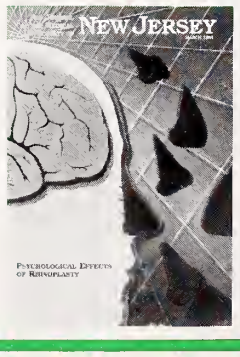
DOCTORS' NOTEBOOK

235 **Trustees' Minutes: January 15, 1984**
236 **President's Column,** Alexander D. Kovacs, M.D.
237 **UMDNJ Notes,** Stanley S. Bergen, Jr., M.D.
237 **MSNJ Auxiliary,** Mrs. Gale Wayman
238 **AMNJ Report,** Paul J. Hirsch, M.D.
238 **Physicians Seeking Location in New Jersey**

MSNJ DEPARTMENTS

241 **CME Calendar**
247 **Letters to the Editor**
249 **Book Reviews**
251 **Obituaries**
253 **Information for Authors**

On The Cover: Do people who undergo a change in appearance change in a positive psychological sense? Drs. Glasgold and Horowitz assess the consequences of rhinoplasty to answer this question. The full story begins on page 187. The cover illustration is by Glenna Deutsch.



AID SERVICE CORPORATION
Specializing in allergy and immunology testing.

One of our greatest contributions to medicine is giving you more time to practice and an opportunity to provide more services for your patients.

MODERN

Over the years you may have heard a lot of controversy about the modified RAST test versus the old scratch and stick test methods of allergy diagnosis. What you haven't heard much about is how to modernize and upgrade your practice so that you can get more time for the things you really want to do. AID can help you with that.

SAFE and ACCURATE

Because we offer a safe, efficient and accurate method of providing the patient with fast, precise, definitive allergy diagnosis and treatment capability, we can save you the irreplaceable time you'd lose by continuing to perform skin tests. If you are referring patients for these tests now, we can offer to you a system that allows you to confirm an allergy diagnosis by merely drawing a blood sample. Treatment extracts based on serum levels of specific IgE are available on your request.

COMPREHENSIVE

Our comprehensive services include a broad range of in-vitro diagnostic tests performed on human serum for the diagnosis of allergic and immune deficiency diseases. In fact, we can perform specific tests for almost 200 different types of allergies on a blood sample. These results can confirm the presence of IgE mediated (type I) allergy and can form the basis for rational immunotherapy based upon the quantitative levels of IgE to a specific allergen.

CONVENIENT

In addition, our method increases the patient's acceptance, while reducing costs, and increases your office productivity by reducing congestion. It's also ideal for infants and children who are afraid of skin tests, patients with skin conditions that contraindicate skin tests and those who can not discontinue medication that would interfere with skin tests.

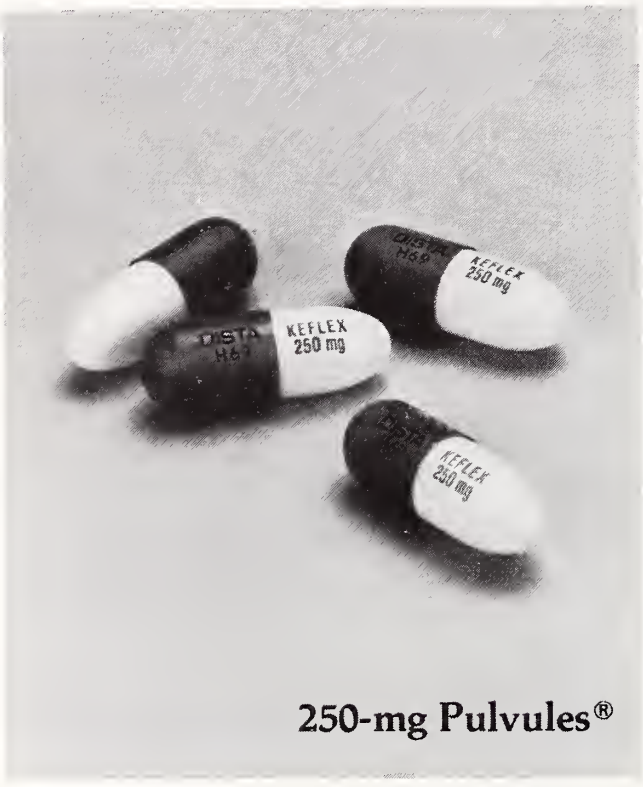
EFFICIENT

If you'd like to spend more time successfully treating patients, instead of wasting time and energy on costly and time-consuming methods, call your AID expert today.

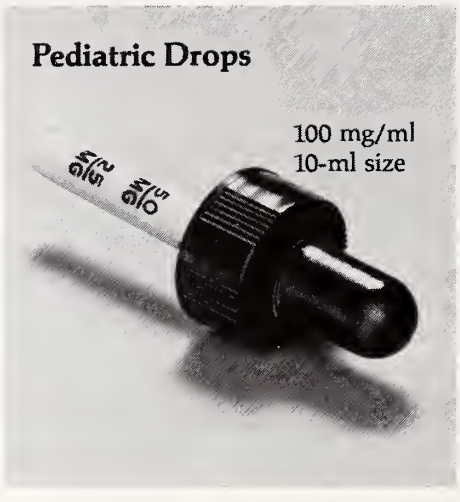
Allergy Immunology Diagnostic Service Corp.
P.O. Box F
Maywood, New Jersey 07607
(201) 836-2844
or call toll-free:
(800) 631-1379

AID SERVICE CORPORATION uses quality reagents from VENTREX LABS, INC.

easy to take







Keflex®
cephalexin

Additional information available
to the profession on request.

DISTA
000823

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

MEMBERSHIP NEWSLETTER

MSNJ

THE MEDICAL SOCIETY OF NEW JERSEY VOLUME 9

MEDIA TECHNIQUES SEMINAR

The Council on Public Relations and MSNJ are aware of the necessity of enlightening our membership with the proper procedures for dealing with the various media.

There was considerable enthusiasm from the physicians who attended the first seminar on media techniques and all their suggestions have been incorporated into the second seminar to make it even better.

This is an excellent opportunity to learn how to handle media interviews and gain exposure to the various public relation techniques. Outstanding media personalities will be participating in this seminar. There will be ample opportunity for questions and answers and role play sessions.

MSNJ will be offering its Second Media Techniques Seminar at the Executive Offices, Two Princess Road, Lawrenceville, on Wednesday, March 21, 1984, from 9:00 A.M. to 4:00 P.M. Luncheon will be served.

The registration will be limited to the first 50 applicants. There will be a fee of $30 to cover expenses and lunch. This is a tax-deductible expense and a worthwhile experience.

MEDICAL BRIEFS

Prostate Cancer Diagnosis—A technique for diagnosing cancer of the prostate using a needle biopsy procedure appears to offer advantages over the use of tissue removal via the urethra. Using needle biopsy, the needle is passed through the perineum between the anus and the scrotum into the prostate gland. A sample of prostatic tissue is aspirated for microscopic examination. This is much less traumatic than tissue extracted via the urethra. There also is less possibility of seeding cancer cells into the circulation of the vascular system.

Prostate Surgery—Pathological changes in the prostate gland that result in an enlargement of the prostate, particularly in older men, frequently have been treated by using the transurethral resection (TUR). A new procedure developed at John Hopkins Hospital and reported in *Prostate* (4:473, 1983) offers a technique that spares the nerves of the penis. As such, it is unlikely to cause lasting impotence. The new procedure is performed through the lower abdomen and the completeness with which all tumor tissue is removed makes it likely that the new technique will become the treatment of choice.

Joint Pain and Beta Blockers—It has been reported in the *British Medical Journal* (287:1256, 1983) that 19 patients who were receiving beta blockers for heart disease or the treatment of hypertension complained of joint pain and swelling. The joint symptoms quickly cleared up when the beta blockers were removed. Practolol and propranol were the drugs used. It was suspected that the drying effect of the beta blockers in the joint that are naturally lubricated with synovial fluid may have been the cause. Beta blockers also have a drying effect on other normally moist surfaces such as the eye, nose, and mouth. Patients developing joint pain while on beta blockers can be reassured and treated for their discomfort.

PREFERRED PROVIDER ORGANIZATIONS*

PPOs generally are designed to accomplish objectives that stem directly from the reasons for their establishment:

- They usually are established as a response to competitive pressures in the local health care market such as an HMO or an increased number of physicians competing for patients in an area. They also may be established by employers as a means to gain some control over health care expenses.
- The PPOs overall goal is to provide easily accessible high-quality care at lower rates, thereby attracting a larger share of the patient market.
- In order to accomplish this purpose the PPO must be able to provide cost-effective medical care while maintaining high standards of quality and access.

There are essentially three ways in which a PPO can work toward its objective of cost effectiveness in the delivery of medical care. It can:

*Reprinted with permission from *A Physician's Guide to Preferred Provider Organizations*, American Medical Association, 1983.

Attendance at the Board of Trustees' Meetings: County and Specialty Societies, Academy of Medicine of New Jersey, and Auxiliary
May 1983—December 1983

Atlantic County

Bergen County

July 17	Marc J. Crilly, M.D., President-Elect
September 18	Marc J. Crilly, M.D., President-Elect
November 20	Marc J. Crilly, M.D., President-Elect
	Peter A. Beaugard, M.D.
December 18	Marc J. Crilly, M.D., President-Elect

Burlington County

December 18	Rodolfo C. Pascual, M.D., President-Elect

Camden County

September 18	Louis L. Keeler, M.D., President
November 20	S. Thomas Carter, Jr., M.D.
	Louis L. Keeler, M.D., President
	Joseph A. Riggs, M.D.
December 18	Louis L. Keeler, M.D., President
	Lindsay L. Pratt, M.D.
	Ralph A. Skowron, M.D.

Cape May

Cumberland

November 20	L. Willis Allen, M.D., Immediate Past-President

Essex County

May 2	Mr. Arthur Ellenberger, Executive Secretary
	Carolyn W. Watson, M.D.
June 12	Carolyn W. Watson, M.D.
July 17	L. Arne Skilbred, M.D., Past-President
	Carolyn W. Watson, M.D.
September 18	Bernard Robins, M.D.
	Carolyn W. Watson, M.D.
November 20	Peter Amirata, Jr., M.D., President
	Carolyn W. Watson, M.D.
December 18	Bernard Robins, M.D.
	Carolyn W. Watson, M.D.

Gloucester County

November 20	John S. Owens, M.D., President
December 18	Churchill L. Blakey, M.D., Secretary

Hudson County

May 12	Charles L. Cunniff, M.D.
June 12	Charles L. Cunniff, M.D.
	Chester R. Rydwin, M.D., President
July 17	Charles L. Cunniff, M.D.
September 18	Charles L. Cunniff, M.D.
	Janet Geraghty-Deutsch, M.D.
	Mrs. Adelene F. Lynch, Executive Secretary
	Frank J. Primich, M.D.
November 20	Charles L. Cunniff, M.D.
	Joseph W. Fleisher, M.D.
	Janet Geraghty-Deutsch, M.D.
	Frank J. Primich, M.D.
	Chester R. Rydwin, M.D., President
December 18	Janet Geraghty-Deutsch, M.D.
	Frank J. Primich, M.D.
	Chester R. Rydwin, M.D.

Hunterdon County

Mercer County

June 12	Mrs. Joey Huddy, Executive Secretary
July 17	Mrs. Joey Huddy, Executive Secretary
	William F. Wittenborn, Jr., M.D., President
September 18	Mrs. Nancy Baron, Assistant Executive Secretary
	Michael J. Larkin, M.D.
November 20	Mrs. Joey Huddy, Executive Secretary
	Michael J. Larkin, M.D.
	Ms. Anne Petchel
December 18	Michael J. Larkin, M.D.

Middlesex County

May 2	Mrs. Mary Alice Bruno, Executive Director
June 12	Mrs. Mary Alice Bruno, Executive Director
July 17	Mrs. Mary Alice Bruno, Executive Director
September 18	Mrs. Mary Alice Bruno, Executive Director
November 20	Mrs. Mary Alice Bruno, Executive Director
	Jon Marsicano, M.D.
December 18	Mrs. Mary Alice Bruno, Executive Director
	Norval F. Kemp, M.D., President-Elect

Monmouth County

June 12	Albert J. Kolarsick, M.D., Past-President
September 18	John E. Bocker, M.D., President
	Mrs. Patricia Klemm, Executive Secretary
November 20	John E. Bocker, M.D., President
	Mrs. Patricia Klemm, Executive Secretary
December 18	John E. Bocker, M.D., President
	Mrs. Patricia Klemm, Executive Secretary

Morris County

June 12	Arthur Ginsburg, M.D., President-Elect
July 17	Arthur Ginsburg, M.D., President-Elect
September 18	Allan L. Gardner, M.D., President-Elect
November 20	Arthur Ginsburg, M.D., President
	James B. Massengill, M.D.
December 18	Martin L. Cohen, M.D.
	Arthur Ginsburg, M.D., President

Ocean County

November 20	Michael C. DiBella, M.D., President
	Edward D. Fiore, M.D., President-Elect
December 18	Michael C. DiBella, M.D., President

Passaic County

September 18	Mr. William T. McGuire, Executive Director
	Gerald H. Rozan, M.D., President
November 20	Mr. William T. McGuire, Executive Director
	Gerald H. Rozan, M.D., President
December 18	Mr. William T. McGuire, Executive Director
	Gerald H. Rozan, M.D., President
	Roberta G. Rubin, M.D.

Salem County

May 2	Mary T. DiMedio, M.D.
November 20	Amante N. DeCastro, M.D., President
	Stephen K. Park, M.D., President-Elect

Somerset County

July 17	Albert M. Doswald, M.D., President

Sussex County

Union County

May 2	Frank R. Romano, M.D., Past-President
	Mrs. Ethel Stevens, Executive Director
June 12	Mrs. Ethel Stevens, Executive Director
July 17	Frank R. Romano, M.D., Past-President
	R. Gregory Sachs, M.D., Secretary
September 18	Frank R. Romano, M.D., Past-President
	Mrs. Ethel Stevens, Executive Director
November 20	Frank R. Romano, M.D., Past-President

Attendance at the Board of Trustees' Meetings: County and Specialty Societies, Academy of Medicine of New Jersey, and Auxiliary
May 1983—December 1983

(continued)

December 18	Frank R. Romano, M.D., Past-President Mrs. Ethel Stevens, Executive Director

Warren County

November 20	Volmar A. Mereschak, M.D., President

New Jersey State Society of Anesthesiologists

June 12	Stanley Bresticker, M.D.
July 17	Stanley Bresticker, M.D.
September 18	Stanley Bresticker, M.D.
November 20	Stanley Bresticker, M.D.
December 18	Stanley Bresticker, M.D.

New Jersey Dermatological Society

June 12	Frederick Haberman, D.O.
November 20	Gabriel Sciallis, M.D., President
December 18	Frederick Haberman, D.O.

New Jersey Chapter, American College of Emergency Physicians

June 12	Rudolf E. Schwaeble, M.D.
July 17	Rudolf E. Schwaeble, M.D.
September 18	Rudolf E. Schwaeble, M.D.
November 20	Rudolf E. Schwaeble, M.D.
December 18	Rudolf E. Schwaeble, M.D.

New Jersey Society of Internal Medicine

May 2	Frank J. Malta, M.D., Past-President
June 12	Frank J. Malta, M.D., Past-President
July 17	Frank J. Malta, M.D., Past-President
September 18	Frank J. Malta, M.D., Past-President
November 20	Frank J. Malta, M.D., Past-President
December 18	Frank J. Malta, M.D., Past-President

New Jersey Association of Medical Specialty Societies

May 2	Frank J. Malta, M.D., Vice-President
June 12	Stanley Bresticker, M.D., President Frank J. Malta, M.D., Vice-President
July 17	Stanley Bresticker, M.D., President Frank J. Malta, M.D., Vice-President
September 18	Stanley Bresticker, M.D., President Frank J. Malta, M.D., Vice-President
November 20	Stanley Bresticker, M.D., President Frank J. Malta, M.D., Vice-President
December 18	Stanley Bresticker, M.D., President Frank J. Malta, M.D., Vice-President

Medical Womens Association of New Jersey

September 18	Roberta G. Rubin, M.D.

New Jersey Neurosurgical Society

May 2	Lawrence Strenger, M.D.

Obstetrical and Gynecological Society of New Jersey

November 20	John D. Franzoni, M.D.
December 18	Courtney A. Malcarney, M.D., President

New Jersey Academy of Ophthalmology and Otolaryngology

July 17	Saul M. Tischler, M.D.
September 18	Saul M. Tischler, M.D.

New Jersey Orthopaedic Society

September 18	Edmund R. Kappy, M.D., President-Elect

New Jersey Society of Pathologists

September 18	William V. Harrer, M.D., President
November 20	William V. Harrer, M.D., President
December 18	William V. Harrer, M.D., President

New Jersey Society of Physical Medicine and Rehabilitation

June 12	Robert Iskowitz, M.D, Member-at-Large
July 17	Robert Iskowitz, M.D, Member-at-Large
September 18	Robert Iskowitz, M.D, Member-at-Large
November 20	Robert Iskowitz, M.D, Member-at-Large

American College of Physicians-New Jersey

July 17	Norval F. Kemp, M.D.
September 18	Norval F. Kemp, M.D. David A. Willard, M.D.

New Jersey Psychiatric Association

June 12	John C. Patterson, M.D., President
July 17	John C. Patterson, M.D., President
September 18	John C. Patterson, M.D., President
November 20	John C. Patterson, M.D., President
December 18	John C. Patterson, M.D., President

Radiological Society of New Jersey

September 18	Alan Herschman, M.D., President Albert J. Salzman, M.D., Liaison

New Jersey Rheumatism Association

June 12	William E. Ryan, M.D., Liaison
July 17	William E. Ryan, M.D., Liaison
September 18	William E. Ryan, M.D., Liaison
November 20	William E. Ryan, M.D., Liaison
December 18	William E. Ryan, M.D., Liaison

Academy of Medicine of New Jersey

September 18	Mr. Charles J. Heitzmann, Executive Director
November 20	Mr. Charles J. Heitzmann, Executive Director Sherman Garrison, M.D.

Medicial Society of New Jersey Auxiliary

June 12	Mrs. Gale Wayman, President
November 20	Mrs. Gale Wayman, President

- Select hospitals and physicians to participate who already demonstrate a track record of providing quality care at lower cost;
- Set up the reimbursement mechanisms to create positive incentives for cost-conscious medical practice; and/or
- Institute control mechanisms designed to eliminate what the PPO considers to be unnecessary services and/or modify imprudent behavior from within the organization.

Early in the planning process of establishing a PPO, decisions must be made with regard to the scope of the organization; i.e. the number of providers to be involved, the number of enrollees projected, the projected intensity and frequency of services that will be provided, and so forth. As with the establishment of an IPA, the size of the enrolled population to be served and the breadth of the services to be offered will be guided by the capacity of the organization, or the number of providers involved. There is a trade-off to be made in deciding on the size of the organization: while participation by a large number of physicians in the community may facilitate better acceptance of the plan by both patients and physicians, participation by a smaller number may mean that those physicians who affiliate with the PPO will be more committed to the successful achievement of its goals and objectives. In addition, communication between the plan's management and its member physicians can be more effective when fewer people are involved.

Most PPOs are composed of both institutional and professional providers. The methodology used to select providers to participate in a PPO may vary with state laws, the nature of the sponsoring or motivating entity, and the category(ies) of costs over which the purchaser or organizer is most eager to exert an influence. The selection process also may not be the same for both physicians and hospitals within a single PPO.

Two alternative physician recruitment approaches may be considered in order to maximize the cost effectiveness of the PPO:

1. Criteria can be developed by which each physician's cost-effectiveness track record would be measured and compared to pre-established upper and lower limit parameters as a prerequisite for participation; or

2. All physicians can be permitted to participate initially, and utilization and cost criteria can serve to accomplish elimination of physicians who turn out not to be cost effective within the framework of the plan.

There are advantages and disadvantages inherent in both schemes. One advantage to the use of preselection criteria is that by the time the participating physician group has been selected, the organization would have a good idea of what could be expected (especially the first year) in terms of cost-conscious behavior; this would have a bearing on other marketing and financial planning issues. On the other hand, an advantage to a more open policy might be that participation by a larger number of physicians in the community would facilitate better acceptance of the plan by both physicians and patients.

In some states (e.g. Virginia) the law applicable to PPO types of arrangements is written in such a way as to preclude insurers from establishing terms and conditions which "discriminate unreasonably against or among such health care providers.... No hospital, physician, or other provider ... willing to meet the terms and conditions offered to it or him shall be excluded." There is always considerable room for judicial interpretation regarding what constitutes "unreasonable" discrimination. However, it may be that exclusion of a physician from participation in the PPO due to consideration of that physician's past practice profiles might be considered unreasonable if he declared himself willing to abide by the terms and conditions of the contract. In states which have such provisions, therefore, the PPO might be obliged to establish an open initial participation policy and clear criteria for cost-effectiveness expectations.

Some PPOs have been organized to include certain categories of providers while excluding others. Blue Cross/Blue Shield of Minnesota's AWARE program is a PPO type of arrangement that applies the prudent buyer concept only to hospitals and hospital charges. The prudent buyer concept involves the creation of a price or charge differential in such a way that the patient is free to choose between a less expensive provider option with fewer out-of-pocket costs to himself, or a more expensive provider option that will result in a greater out-of-pocket expense. The cost to the insurer remains the same regardless of the option the patient chooses. Thus, participating AWARE hospitals accept the Blue Cross/Blue Shield payment as full reimbursement for services for delivered. Non-participating hospitals do not, and may bill the patient for any remaining balance.

Aetna Life and Casualty's CHOICE program at Evanston Hospital (Evanston, Illinois) is a plan which seeks to control costs by enlisting the participation of a hospital and its entire medical staff and then channeling all referrals for specialty and hospital care to that institution, while allowing enrollees in the plan to select any primary care practitioner in the community. There are no "preferred" primary practitioners under the CHOICE plan. However, if a primary care physician whose patient elects the CHOICE program agrees to continue to treat his patient under the conditions of the plan, he is in essence agreeing to abide by the CHOICE plan referral procedures.

The negotiation of the fee schedule is another area which varies greatly from one PPO to another. There usually is, although not always, a discount involved. Physician fees were reported in the AMA Survey of PPOs to be discounted by 10 to 20 percent from UCR; hospitals reportedly discount their average daily charge as much as 15 percent. Physicians' fees may either be stipulated in the contract (to be accepted or rejected by the physician) or negotiated between the provider and the PPO. More often than not, physicians' fees are reported to be calculated using Relative Value Scales with a different conversion factor for each physician. These conversion factors themselves are, in some cases, the negotiable item in the participation agreement.

Hospital payment rates are grouped and negotiated somewhat differently than physicians' fees. Hospital rates may be unilaterally stipulated in the contract, or they may be negotiated. If they are negotiated, services most often are categorized and negotiated separately. For example, a hospital might negotiate different discount rates or prices for medical, surgical, and obstetrical services, as well as for such services as alcohol detoxification. Hospital rates have also been set at a direct percentage discount from the average daily charge. In some hospitals, the amount of the discount was related to the level of volume delivered by the PPO, i.e. the more business the PPO brought to the hospital, the larger the discount it received. In a few cases, hospitals have negotiated different prices by Diagnosis Related Group (DRG).

The fee schedules often include one or more of a variety of incentives to the physicians to deliver care in the most cost-effective setting possible. For example, some organizations have established fee schedules such that a physician will be reimbursed 85 percent of UCR for performing certain specified procedures in the hospital, 100 percent of UCR for performing those same procedures in an outpatient setting, and 110 percent of UCR for delivering those services in his own office. Some PPOs have established lists of procedures for which they will not reimburse inpatient care unless the physician can demonstrate a medical justification for hospitalization.

Some PPOs do not require that physicians and hospitals offer discounts in order to participate in the arrangement. These are often the same organizations which utilize preselection criteria in choosing the participating providers. The inherent assumption is that the PPO already has selected the most efficient and

cost-effective providers in the community and that discounts are therefore not necessary in order to effect savings. Organizers who choose this methodology may do so because they are convinced the efficiency is more important than discounts in containing costs and they wish to avoid providers whom they believe may hospitalize patients unnecessarily.

One of the characteristics that distinguishes a PPO from some other alternative delivery and financing systems is that its providers are reimbursed on a fee-for-service basis. Many different organizational structures have been set up to accomplish the payment objective efficiently. The PPO itself may be just an intermediary organization or broker between the purchaser and the group of providers designated as "preferred;" its functions are primarily administrative and marketing. Consequently, the PPO does not usually have a large staff or the organizational capacity to process a great deal of paperwork. Thus, it is not uncommon for both the provider entity (hospital or group of physicians) and the purchaser (insurer or employer) to perform some of the claims review and processing functions. The majority of the organizations surveyed by the AMA required a claim to be submitted directly to the payor; some required claims submission to the PPO. In either case the providers often batch their own claims and do medical necessity review prior to submitting them. If the claims are submitted to the payor, payment is usually made directly to the provider, often within two weeks of submission. If the claim is submitted to the PPO, the PPO may pay the providers directly and assume responsibility for collection from the purchaser, or it may pass the claim to the purchaser for payment to the provider. Either way the timeframe for payment is usually longer than that for claims submitted directly to the payor.

Some PPO provider participation agreements specify a turn-around time for claims payment; some do not. Some contracts contain a provision for interest to be paid on claims that are not paid within the specified timeframe. If the contract does not contain a specific provision regarding the turnaround time for claims payment, it is probably safe to assume that the PPO does not plan to include speedy claims payment as a participation incentive.

Since the patients are not usually locked-in to the PPO arrangement and since the physicians are paid on a fee-for-service basis, utilization review is seen by many employers and purchasers to be the key to cost containment for the PPO arrangement. There is concern, however, that the emphasis placed by PPOs on cost containment may lead to a decreased emphasis on the quality of the care that is delivered. Given the current lack of performance data, it is premature to make any definite statements regarding either the cost effectiveness of PPOs or their effect on quality of care.

Collectively, quality assurance and utilization review programs assess the way health services are provided, identify medical, administrative, and fiscal deficiencies, and implement actions to correct these deficiencies. Consensus has yet to be reached on a definition of "quality care" and some even argue it defies definition. General agreement does exist, however, that quality of care can be inferred by examining the structures in place to provide care, the processes by which care is delivered, and those measurable outcomes of provided services which are available. The focus on quality assurance programs is to insure that standards of medical care are maintained in practice.

Utilization review programs, in contrast, have a more narrow focus—assuring appropriate, cost-effective utilization of health resources (particularly hospital and referral specialist services). Consequently, these programs monitor member utilization patterns and physicians' practice patterns to identify deviations from established norms and take actions to correct deficiencies as appropriate.

Appropriate physician support and a suitable organizational structure are important facets of a successful quality assurance and utilization review program. A critical element in developing health professional support for quality assurance and utilization review programs is the concept of peer review. Physician input into the design and implementation of these programs is, therefore, very important.

An essential step in the development of a credible quality assurance program is the identification of program goals. These goals provide a framework for program activities and facilitate evaluation of the program's success. Program goals should be consistent with the key function of the quality assurance program, e.g. assure high quality care; identify problems in the health services delivery system; identify and implement corrective actions for identified problems; and measure performance after corrective action is taken to document change.

Program objectives should be established to document the organization's commitment to specific program activities. Program objectives should be: measurable to permit program evaluation; realistic, thereby fostering a sense of purposefulness among the physicians; and supported by a consenus among the physicians.

The primary focus of quality assurance program activities should be in areas of known or suspected problems, as well as areas of general interest. The results of quality assurance investigations and studies should be documented and communicated to appropriate physician panel members and physician leadership.

As with quality assurance goals, utilization review goals should be broadly stated to: insure that medically necessary services are provided in a cost-effective manner; and limit the PPOs financial responsibility to providing only medically necessary covered services.

By contrast, however, utilization review program objectives are more easily defined. These objectives should be measurable, realistic, and medically significant.

Types of utilization review performed by PPOs include: preadmission certification, preprocedure authorization, concurrent review of hospital stays, second surgical opinions, medical necessity review, level of care review, review of hospital outpatient services, ancillary services review, review of selected diagnoses, review of services in physician's offices, and retrospective profile analysis and denials. Almost all of the PPOs surveyed by the AMA utilize concurrent review of hospital length of stay, and approximately half use preadmission certification. Many organizations have second surgical opinion programs, and most develop

cost and utilization profiles for both physicians and hospitals.

An important factor in the success of a utilization review program for PPOs is the issue of who designs, controls, and conducts the review. The AMA Survey showed that approximately 40 percent of all reviews are conducted by the PPO entities themselves. Contracting physicians conduct almost half of all reviews; another 20 percent are conducted by outside contractors (often private review organizations or fiscal intermediaries). Among the organizations surveyed, the PPOs review programs were almost always designed by the PPO organizers, sometimes with input from physicians.

The utilization review system is intrinsically tied to the reimbursement mechanism. All PPOs surveyed by the AMA reported that medical necessity review of each submitted claim is performed prior to rate assignment and payment. This review is conducted by the PPO itself prior to submission to the payor or, as often is the case with an insurance carrier-sponsored plan, by the purchaser prior to payment authorization.

The design of the benefits plan and coverage levels in PPOs is usually a flexible process. The vast majority of plans which responded to the AMA Survey allowed employers or purchasers to select from among a variety of benefit packages for their subscribers, or to negotiate a specific package which met the special needs of their employees. A few plans, however, have established fixed coverage programs which they market to area employers. In these instances the contract negotiation process between the PPO and the purchaser usually involves only the price of the contract; levels of coverage and services to be covered are not negotiable. Over 90 percent of the plans surveyed, however, allowed the purchaser to stipulate the needs of its population, and the benefits package and coverage levels were then designed with those needs in mind. Most of the PPOs surveyed offered a wide range of services (Table). Those plans which market a fixed package of benefits tend to cover slightly fewer services than average.

Under a preferred provider arrangement the patient's benefits may be more extensive (in that he may receive first dollar coverage) if he uses the preferred providers than if he goes to a nonpreferred provider (in which case he is responsible for whatever additional copayments or deductibles are stipulated in the contract). In some cases, the PPO requires a nominal copayment or deductible to be paid by the patient even if he uses a preferred provider; however, even under these plans the patient's out-of-pocket costs are still much greater if he goes to a nonpreferred provider. Thus, a preferred provider arrangement provides benefits regardless of whether the patient uses a preferred or nonpreferred provider. An "Exclusive Provider Organization," however, provides no benefit coverage at all if the patient goes to any provider other than a designated panel member. (There are very few of these organizations being developed to date and several states have laws specifically prohibiting the development of such plans.)

Many plans also include contract provisions to encourage utilization of the outpatient setting rather than the more costly inpatient setting for certain services. For example, under some arrangements, specified services or procedures will not be covered unless they are delivered or performed on an outpatient basis. In other cases, the patient pays a higher copayment or deductible for services which can be provided on an outpatient basis if they are delivered in an inpatient setting.

TABLE

*List of Services Usually Covered Under Preferred Provider Arrangements**

- Physician services
- Inpatient care
- Outpatient care
- Emergency room care
- Mental health services
- Treatment-referral for alcohol and chemical dependence
- Diagnostic laboratory services
- Diagnostic and therapeutic x-ray services
- Well child care
- Health evaluation for adults
- Eye and ear examinations for children
- Immunizations
- Prescription drugs
- Durable medical equipment
- Prosthetic devices

Additional Services Often Covered

- Infertility services
- Long-term rehabilitative services
- Long-term care services
- Intermediate care services

*Source: AMA Survey of PPOs, February-August 1983. It is important to note that coverage levels will vary from one PPO organization to another.

One of the reasons cited by physicians for joining a PPO is their expectation of the potential for additional patients and other advantages to be derived from the marketing efforts of the PPO itself. This can only be accomplished if the PPO has done a careful market analysis and developed a marketing plan. The market analysis should take into account the following factors:

- Articulation of the potential demand or need for a PPO in the area.
- The extent of the planned service area.
- An area employer profile.
- An analysis of the likelihood of penetrating this market.
- The major payors in the area and their relative market shares.
- An identification of potential major competitors.

Since the great majority of potential subscribers will be enrolling through their place of work, it is important to acquire good information about the employed population of the area. PPO developers must know:

- The number of employers in the area, categorized by size of employee work force and type of work.
- Which insurance companies have the major share of the market.
- The level of health benefits commonly offered by employers.
- What the premium levels are.
- What portion of the premium is paid by the employer.

The more specific information that can be acquired, the more effective the marketing plan will be. Much of the necessary information only can be obtained by actually surveying the employers in the area.

The organization and implementation of a PPO does not appear to require as sizable a capitalization as is required to set up a Health Maintenance Organization. Estimates of start-up costs among PPOs surveyed averaged approximately $40,000, and ranged from zero to $200,000. Start-up costs are incurred primarily for market analysis and actuarial consultants. In the case of physician-sponsored PPOs, start-up costs usually are financed by the physicians. If the plan does not deliver results in terms of patient volume within the projected start-up timeframe, these physicians may risk an investment loss.

Once organized, a PPO also does not engender as much overhead expense as an HMO. In part this is because the PPO itself usually has a very small staff serving as an intermediary broker between two already established entities: the purchaser and a group of providers (physicians and hospitals in the community). There is no requirement for large offices or expensive equipment in such a contracting or brokering arrangement. Most of the resources required by the PPO are secured on a contract basis, not purchased or leased. Often this includes data collection and analysis systems contracted for through local insurers.

The PPO does serve some administrative and marketing functions, however, for which payment must be made. PPOs can and do charge their providers or their purchasers or both, for the administrative services of the PPO. If the purchasers are assessed a fee, it may be on a percent of premium or a per subscriber basis. Provider charges may take the form of a monthly membership charge, an inital entrance fee, or both.

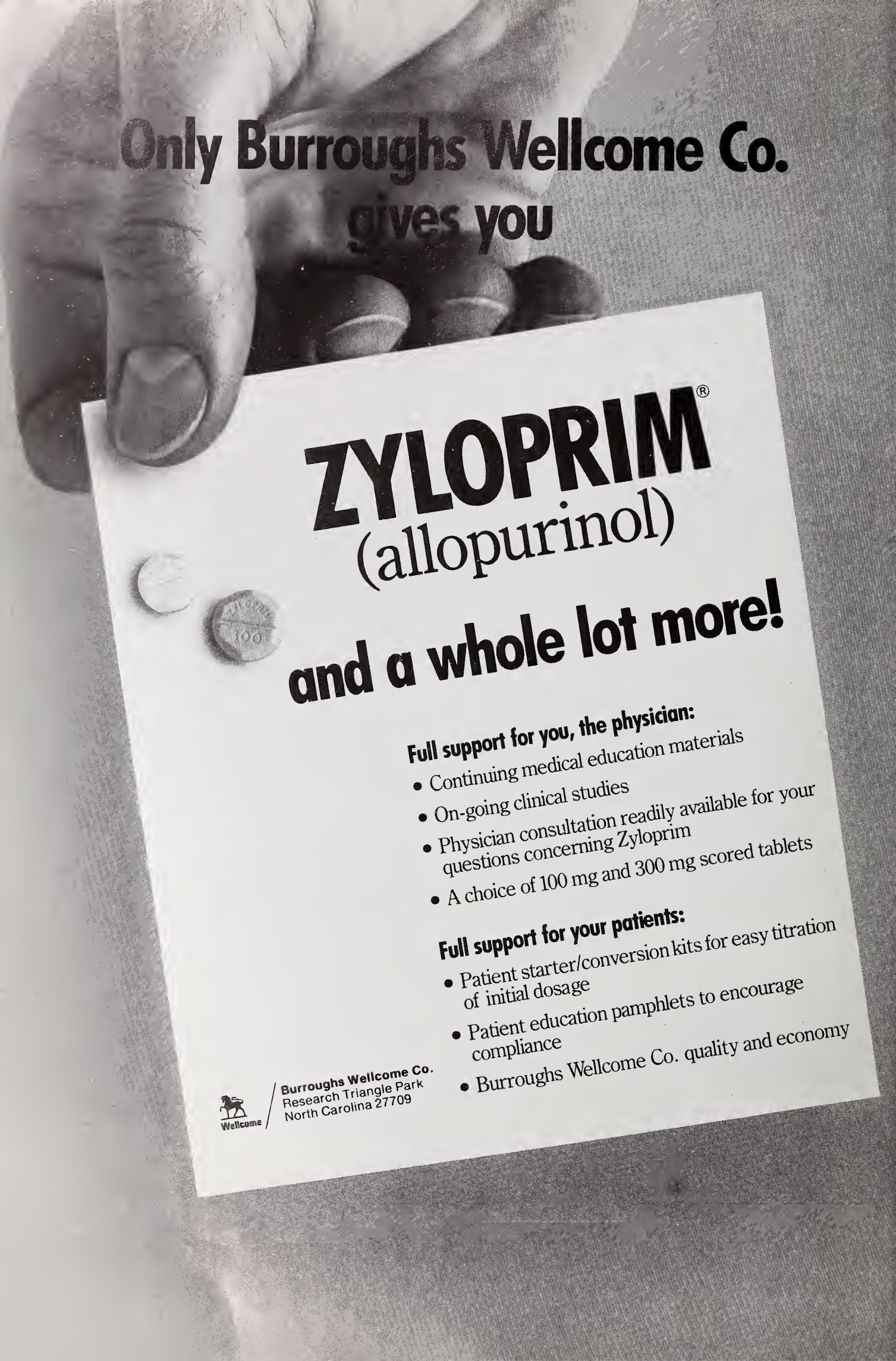
In addition, while there has not been an infusion of government funds into the development of these organizations, there have been some private funds from such sources as large employers or insurance companies interested in developing the concept. The Robert Wood Johnson Foundation recently awarded the San Diego Committee for Affordable Care—a community-wide coalition of employers, consumers, unions, and providers—a grant to develop an areawide PPO.

Another characteristic of PPOs is the low level of financial risk involved for the participating physician in a plan which is reimbursed on a fee-for-service basis. However, there are a few PPOs beginning now to experiment with the notion of risk-sharing as an added cost containment incentive. One example of this type of plan is the Physician's Health Plan in Minnesota. This plan pays participating physicians on a fee-for-service basis, but retains 20 percent of the agreed upon fees in an escrow fund. At the end of the year, if promised savings have not been generated, these funds must be shared with the purchasers. If savings have accrued to the purchasers as promised, the funds are divided among the participating physicians. At this point, the distinguishing lines between PPOs and HMOs begin to blur somewhat; the main difference between an arrangement such as is described here and an HMO, is that the PPO arrangement is not capitated. Physician's Health Plan of Minneapolis is, in fact, a long-established IPA which has begun to develop some new business under a selective contracting mechanism. Thus, a risk arrangement such as is described is possible because the IPA is also an insurer and as such is licensed by the state to collect and hold funds.

PPO failure can be considered within several contexts: failure to achieve the cost-containment objective of the purchaser or organizational failure due either to inadequate internal management or contractor failure. As with HMOs, failure can occur as the result of purchaser failure, undercapitalization, or inadequate management practices. Moreover, PPOs are a response to competitive pressures. Their incentives operate in a competitive climate and in the context of alternative choices. Thus, the design of the PPO incentives relative to other consumer options is very important. Financial viability of PPOs is also an issue. PPOs, like other health care delivery and financing plans, need to balance sound financial management against prudent selection of purchaser groups and providers to help prevent failure. Finally, there may be significant legal issues to overcome, including antitrust issues for which precedents have not yet been established.

FINI

Finding faults can be easy, if you forget your own.


Only Burroughs Wellcome Co.
gives you
ZYLOPRIM®
(allopurinol)
and a whole lot more!
Full support for you, the physician:
• Continuing medical education materials
• On-going clinical studies
• Physician consultation readily available for your questions concerning Zyloprim
• A choice of 100 mg and 300 mg scored tablets
Full support for your patients:
• Patient starter/conversion kits for easy titration of initial dosage
• Patient education pamphlets to encourage compliance
• Burroughs Wellcome Co. quality and economy
Wellcome
Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

PROFESSIONAL LIABILITY COMMENTARY*

Liability costs and malpractice claims

Impact of Liability Costs Studied by AMA; Malpractice Claims Increase to 8 Per 100 Physicians; Malpractice Lawsuits Drive Up Ob-Gyn Fees; No Lawsuit Against Hinckley Psychiatrist

A report of an ongoing study attempting to identify the magnitude of the costs of professional liability and to suggest their possible impact upon the nation's expenditures for health care has been released. Commissioned by the AMA House of Delegates at the 1982 Annual Meeting, the study is summarized in a Board of Trustees report, which was referred for consideration to Reference Committee H at the Los Angeles Interim Meeting. The indepth study was conducted by a Committee on Professional Liability appointed for the task and was chaired by John J. Coury, Jr., M.D., a Trustee from Port Huron, Michigan.

The study estimated some of the direct and indirect costs of professional liability in the medical and health care sector, including:

- $1.43 billion to $1.47 billion paid by physicians in 1982 for professional liability insurance, with the prospect that their 1983 premiums will range from a possible $1.65 billion to as much as $1.75 billion.
- A comparable estimated expenditure by the nation's hospitals for professional liability insurance premiums or other protection against claims and suits.
- An additional $2 million to $3 million paid out by physicians in premiums to insure their skilled paramedical employees against legal action.
- $15.1 billion in projected costs annually to patients for "defensive medicine"—additional tests and procedures that physicians sometimes perform in response to the growing professional liability risk.

Costs of professional liability protection for physicians, their skilled employees, and hospitals total an estimated $3.5 billion in 1983. The projected cost of $15.1 billion for defensive medicine represents about 5 percent of the nation's 1982 medical care expenditures of $322 billion.

Faced with the task of developing reasonable estimates of costs for which no central sources of data are available, the Committee on Professional Liability assembled information from a variety of sources and then made projections.

Since there is no national clearinghouse of information on total premiums paid by individual physicians and groups for professional liability coverage, estimates were made based upon data from the physician-owned insurance companies linked to medical societies, from available information on commercial carriers, from insurance company rate tables, and from information obtained in July and August through AMA's Socioeconomic Monitoring System. Economists and lawyers also provided input.

To calculate additional premium costs for covering skilled paramedical employees employed by physicians, the committee verified that the charge for protecting these individuals adds about 2 percent to a physician's insurance bill.

"A projection of $2 million to $3 million of added premium costs could be estimated based upon approximately $200 additional premium costs for each skilled paramedic employed in physicians' offices," the Committee said. (*American Medical News*, December 2, 1983)

MALPRACTICE CLAIMS INCREASE

Information obtained from the AMA's Socioeconomic Monitoring System (SMS) reveals that the average incidence of claims per 100 physicians increased from 3.3 claims per 100 physicians before 1978 to 8 claims per 100 physicians from 1978 through 1983. For certain surgical specialties at greatest risk for suit, the claims per 100 physicians range up to 11.8 per 100 physicians.

The SMS data also revealed that 12.5 percent of all physicians sued hired a lawyer to defend them in addition to the lawyer provided by their insurance company. On average, each physician spent a total of 3.7 days giving depositions, making court appearances, and meeting with attorneys over the last five years on professional liability matters, or 2.7 days per claim.

The SMS survey of 1,240 physicians also sought information about how they responded to increases in professional liability risk. The most common physician responses to the increasing risks of malpractice claims have been to keep more detailed patient records (57 percent), to refer more patients to other physicians (45 percent), and to prescribe additional diagnostic tests (41 percent). (*American Medical News*, December 2, 1983)

DID YOU KNOW . . .

Nationally, malpractice premiums for all physicians added $5 a day to the cost of a hospital stay in 1982,

*This item from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse who are, respectively, Director of the Department and Director of Special Projects.

and $2 to $4 to the cost of every visit to a doctor's office? (*Medical Economics*, December 12, 1983)

Today's medium outlay for malpractice coverage comes to 3.5 percent of gross practice income compared with 3 percent in the 1970s? (*Medical Economics*, November 28, 1983)

Southern California Physicians Insurance Exchange will return $18 million in experience credits and repay $1.3 million in contribution certificates to policy holders? The paybacks will offset a 7.5 percent rate increase for 1984.

MALPRACTICE LAWSUITS DRIVE UP OB-GYN FEES

According to a recent survey by the American College of Obstetricians and Gynecologists (ACOG), malpractice lawsuits are driving up fees. In a poll of its members, ACOG, found in California alone, obstetricians and gynecologists have raised their fees up to 30 percent over the past two years, in part because of increases in professional liability insurance rates. The survey also revealed that lawsuits against these specialists are pushing health care costs upward because physicians are ordering more tests on patients as a defense against litigation. Other survey results: in 1982, physicians and other health care providers paid more than $1.7 billion in malpractice insurance premiums, up 12 percent over 1981; ob-gyns pay the most for malpractice insurance, with more than 30 percent nationally paying at least $15,000 each year for coverage; and many ob-gyns are giving up their obstetrical practice at a younger age primarily to avoid the risk of lawsuits. (*LACMA Physician*, November 7, 1983)

NO LAWSUIT AGAINST HINCKLEY PSYCHIATRIST

A lawsuit against John W. Hinckley Jr.'s former psychiatrist has been dismissed by a federal judge in Denver. The lawsuit had been filed in United States District Court by three of the victims of Hinckley's attempt to assassinate President Reagan on March 30, 1981, including presidential secretary, James Brady. They contended that Dr. John Hopper of Evergreen, Colorado, who treated Hinckley for five months before the attack, should have known that Hinckley would attempt an act of violence.

United States District Court Judge John P. Moore said: "Nowhere in the plaintiffs' complaints are there allegations that Hinckley made any threats regarding President Reagan, or indeed that he ever threatened anyone."

At most, the judge said, the complaint states that if the psychiatrist had interviewed Hinckley more closely, he would have discovered circumstantial indicators of future actions, such as his obsession with actress Jody Foster and the movie "Taxi Driver," which involved a political assassination attempt. (*New Jersey Law Journal*, December 15, 1983)

"MIDLANTIC'S HUNGRY IRA TAKES A BIG BITE OUT OF YOUR TAXES."

"It's getting near that time of the year again. When Federal taxes put the bite on your hard-earned income.

"So bite back with a Hungry IRA from Midlantic.

"Our IRAs help reduce your annual taxable income while you earn tax-deferred interest. With hungry rates and a flexible range of maturities. Plus they're all FDIC insured, with no fees or sales commissions.

"And now, our new Money Market IRA gives you another convenient investment option. Your retirement savings earn money market rates that change to keep pace with current market conditions. And because it has no maturity you can add to it anytime.

"Any one of our IRAs is bound to satisfy your appetite for savings. Because every one of them saves you from taxation. Up to $2000 a year if you're a single wage earner. Up to $2250 if either you or your spouse work. And up to $4000 yearly if you both work.

"Your money will be making money until you retire, when you'll probably be in a lower tax bracket.

"So stop feeding your salary to the IRS. And feed it to your Hungry IRA instead."

FOOD FOR THOUGHT FROM THE HUNGRY BANKERS

MIDLANTIC



Bob Van Buren, Chairman, Midlantic Banks Inc.

ederal regulations require a substantial interest enalty for withdrawals from certificates before aturity. Withdrawals from an IRA plan are taxable s ordinary income in the year of withdrawal and efore age 59½ are also subject to tax penalty.

Member FDIC

Thinking con

Think

As in Blue Cross of New Jersey. *The* single source for computerization. ☐ Because Medical Management Services from Blue Cross now offers a unique automated office system. ☐ Only Blue Cross offers this unique system, because only Blue Cross has the experience in the health care field (half a century's worth!), the data processing know-how and the claims processing expertise to make it all work efficiently and effectively.

The system itself.

You receive a stand-alone system using IBM or Texas Instruments computers that is physically located in your office. It is operated by your office personnel—they do not have to have any data processing experience—and the system is completely under their control at all times.

The software and system support.

This modular system provides a complete software package for your office which utilizes Blue Cross' expertise in health care financing, automated hospital admission/approval systems, automated claims submission, and leadership in paperless processing. Only Blue Cross can offer the benefits of this wealth of experience and offer single source capability for computerization.

Your people receive full and complete training and ongoing support in system operation. We accept full responsibility for hardware and software maintenance.

What the system does for the physician.

Whether you are an individual or group practice, this system will relieve paperwork...provide fast access to necessary patient information...and give you much more time to tend to the clinical aspects of your practice... and, above all, increase the efficiency of the office and the income of the practice! All from a single source for computerization.

Some of what you get with the System:

- An easy-to-use system.
- Instant access to patient account information by account number.

Take a minute to check this list!

- ☐ Your volume is at least 80 patients per week.
- ☐ Your daily cash control and records keeping procedures need to be improved.
- ☐ Your receivables are greater than 17% of your total annual charges.
- ☐ You are forced to write off more than 5% of your net receivables as uncollectable.
- ☐ You are running behind in your insurance billings and collections.
- ☐ Your service bureau already charges you more than $4,200 per year.
- ☐ You experience a high turnover of clerical employees or need to increase the productivity of your present staff.
- ☐ You find it difficult to get complete and current data on patient treatment patterns, facilities utilization, and services on a regular weekly, monthly and annual basis.
- ☐ Your quarterly and annual payroll reports are now done manually.
- ☐ You have difficulty getting useful management information about your practice when you need it.
- ☐ Your "most current" financial statement for the practice is already out of date.

If you have checked off any of the above, you are a candidate for Medical Management Services.

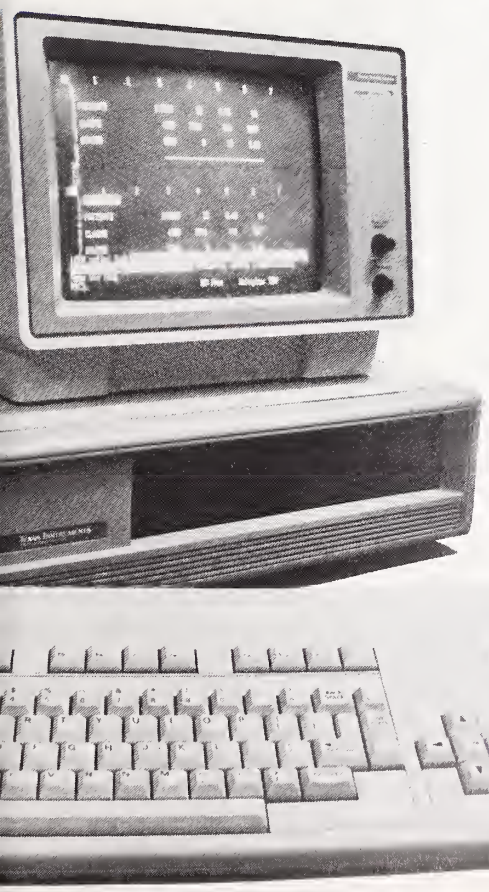
outerization?

blue.✓

- Production of patients' statements on daily, weekly or monthly basis —whichever billing cycle is best for your practice.
- Automatic production of standard insurance (AMA) claim forms.
- A daily charge and collection summary which recaps all daily patient activity.
- An aged accounts receivable trial balance which can be printed on demand.
- Practice productivity reports broken down by procedures and payment classifications (insurance, self-pay, etc.)
- Monthly management reports.
- Medicare payment distribution (20% of co-pay automatically calculated if assignment is accepted).
- Single-date entry for all financial transactions.
- A recall system which prints lists, statistics and "labels."
- Customized reports for special requirements.
- Automatic retention of claims information for rebilling purposes.
- Improvement in cash flow and office efficiency.

Free Office Analysis
Included in the services provided is a free office analysis where a Medical Management Services representative analyzes pertinent data on your current work flow, patient volume, initial set-up for new patients, billing, insurance filing and follow-up. This Office Analysis is a prerequisite for installation and is made at no charge.

Fill out the coupon, or call, for further details and to initiate your Office Analysis.



Medical Management Services

P.O. Box 8
Florham Park, NJ 07932
(201) 966-2710

Blue Cross of New Jersey ®

Medical Management Services
Blue Cross of New Jersey, P.O. Box 8, Florham Park, NJ 07932

☐ Please send me additional information.
☐ Please have a representative call to arrange an Office Analysis.

Dr. _____

Office Address _____

City _____

State/Zip _____ Office telephone _____

® Registered Marks Blue Cross and Blue Shield Association

MSNJ News— Via HIN TV

MSNJ is on the air, as a participant of the Healthcare Information Network. These closed-circuit television programs will cover issues and concerns of physician members and health care professionals.

The Medical Society of New Jersey is on the air! As participants of the Healthcare Information Network (HIN), MSNJ will be sponsoring closed-circuit television programs related to issues and concerns of physician members and New Jersey health care professionals.

The live television shows will be presented to New Jersey hospitals subscribing to the HIN closed-circuit television network. HIN, the first statewide hospital network to broadcast via satellite, began its operation on January 4, 1984. HIN is an interactive, color television system; the hub of the network is a central telecommunications center and a satellite earth station located in Princeton.

Presently, there are 18 hospitals participating in the project: Beth Israel Hospital, Bridgeton Hospital, Clara Maass Medical Center, Hackensack Medical Center, Kessler Institute for Rehabilitation-Kessler West, Memorial General Hospital, Morristown Memorial Hospital, Muhlenberg Hospital, Newark Beth Israel Medical Center, Northern Ocean Hospital System, Inc., Salem County Memorial Hospital, St. Elizabeth Hospital, St. Mary's Hospital-Passaic, St. Peter's Medical Center, Underwood-Memorial Hospital, Warren Hospital, West Hudson Hospital, and West Jersey Health System-Northern and Eastern Divisions.

The programs will be viewed at 1 P.M. on the first, second, and third Tuesday of each month, in three separate series:

1. President's Forum: Hosted by Alexander D. Kovacs, M.D. Dr. Kovacs will meet with selected members of the MSNJ Board of Trustees and chairpersons of various councils and committees to discuss information presented at Board meetings. This program will run on February 7, March 6, April 3, May 1, and June 5.

2. The Impaired Physician: Conducted by David I. Canavan, M.D., Medical Director of the Impaired Physicians Program, MSNJ. Dr. Canavan will describe all aspects of the Impaired Physicians Program from a definition of the problem to identification and confrontation. This series will be on January 10, February 14, March 13, April 10, May 8, and June 12.

3. State of the Art: Moderated by Past President Howard D. Slobodien, M.D. Dr. Slobodien will cover the following subjects: Medicine: A Profession in Transition, Parts 1 and 2, with William Kane, M.D., Norval Kemp, M.D., Alfred Alessi, M.D., Arthur Bernstein, M.D., and Frank Primich, M.D.; MSNJ Legislative Activities with Irving Ratner, M.D., Mr. Joseph Katz, and Mr. Edward Meara; The Medicaid Project with Thomas Bellavia, M.D., Bayard Coggeshall, M.D., and Mr. Thomas Russo; A Report from the AMA with William D'Elia, M.D., and James Todd, M.D.; and Third-Party Payor, with MSNJ Executive Director Vincent A. Maressa, J.D. The programs will run on January 17, February 21, March 20, April 17, May 15, and June 19.

All shows will be live, and viewer participation is anticipated. During the program, an 800 number will be flashed across the screen for individual calls.

Television programming is a new avenue for MSNJ. The educational programs to be presented will allow us to reach more of our membership. One possible way would be for medical staffs to schedule a combined lunch/HIN TV hour—and that way our members could learn more about the profession straight from "the horse's mouth." And, of course, MSNJ leadership would be able to get a direct response from the grassroots level.

MSNJ is keeping up with the times. Cable television no longer is the way of the future: it is today's medium of communication. As they say in show biz, MSNJ is "on line."

G.H.

EDITORIAL

Dropping the Ball: Tennis, Golf, and Alcohol

WILLIAM C. VAN OST, M.D., ENGLEWOOD

The American Medical Society on Alcoholism has only 900 members. With such a small membership, one wonders where our professional sense of values has gone. Physicians must be willing to meet obligations and fight the epidemic of alcohol and drug abuse.

I was leafing through the directory of medical organizations which was published in the April 22/29 1983, issue of *JAMA* (volume 249, no. 16), when, near the end of page 2,154, I read a couple of listings that really miffed me. No—the listings made me feel damned mad; angry enough to sit down and share my opinion with any of my fellow physicians who care to listen.

Listed just above the American Medical Tennis Association (3,300 members) and a bit below the American Medical Golf Association (1,300 members) is the American Medical Society on Alcoholism with only 900 members. Not that I have anything against tennis or golf, but it makes me wonder where our professional sense of values has gone.

For example, there are 15 million kids in the world out there who are living with an alcoholic parent; millions more have reached adulthood bearing the scar of their dysfunctional youth. At least a quarter of our colleagues, if they would admit it, can identify with that older group. Yet, only 5 percent of the population in which alcohol is a central part of one's life receives any help, resulting in life-long feelings of anger, shame, guilt, fear, and confusion. What are we physicians doing to help alleviate at least some of the pain?

A recent Gallup poll revealed that over half of our nation's family members feel that they have in some intimate way been affected by alcohol and drugs. The 17- to 24-year-old age group is the only portion of our population which is experiencing an increasing mortality rate mostly due to violent deaths as a result of alcohol-/drug-related traffic accidents, falls, drownings, murders, and suicides.

We can stamp out polio, diphtheria, and tetanus, and erase smallpox from the face of the earth. Surely, these are examples of preventive medicine at its best. Yet, we allow over 110,000 people to die, directly or indirectly, each year of the disease of alcoholism.

If just one person in your practice died of this epidemic during the past year, what did you do to prevent it? What could you have done? If either of the parents was a drunk, you missed something. If there was alcohol or drug use and you did not know it, you apparently missed something. Why? Perhaps you just did not look, or you did not listen, or you did not feel. Most likely, you just did not ask. Too many of us look upon alcoholism as an accusation, not as a disease; a family disease which, unless diagnosed, destroys victim, family, friends, and neighbors. There is hope: Alcoholism can be treated and it can be prevented if only we physicians would turn aside our prejudices and use our God-given senses to make the diagnosis, treat the disease, and identify and treat the contacts, in an attempt to put a stop to the epidemiological spread.

Get rid of the myths.

Alcoholism is not fussy. It affects rich, poor, black, white, Christian, Moslem, and Jew.

A fact is a fact: One out of every four kids in every practice involving children is depressed and confused by the effects of family alcoholism. If you have not seen them, you have not looked.

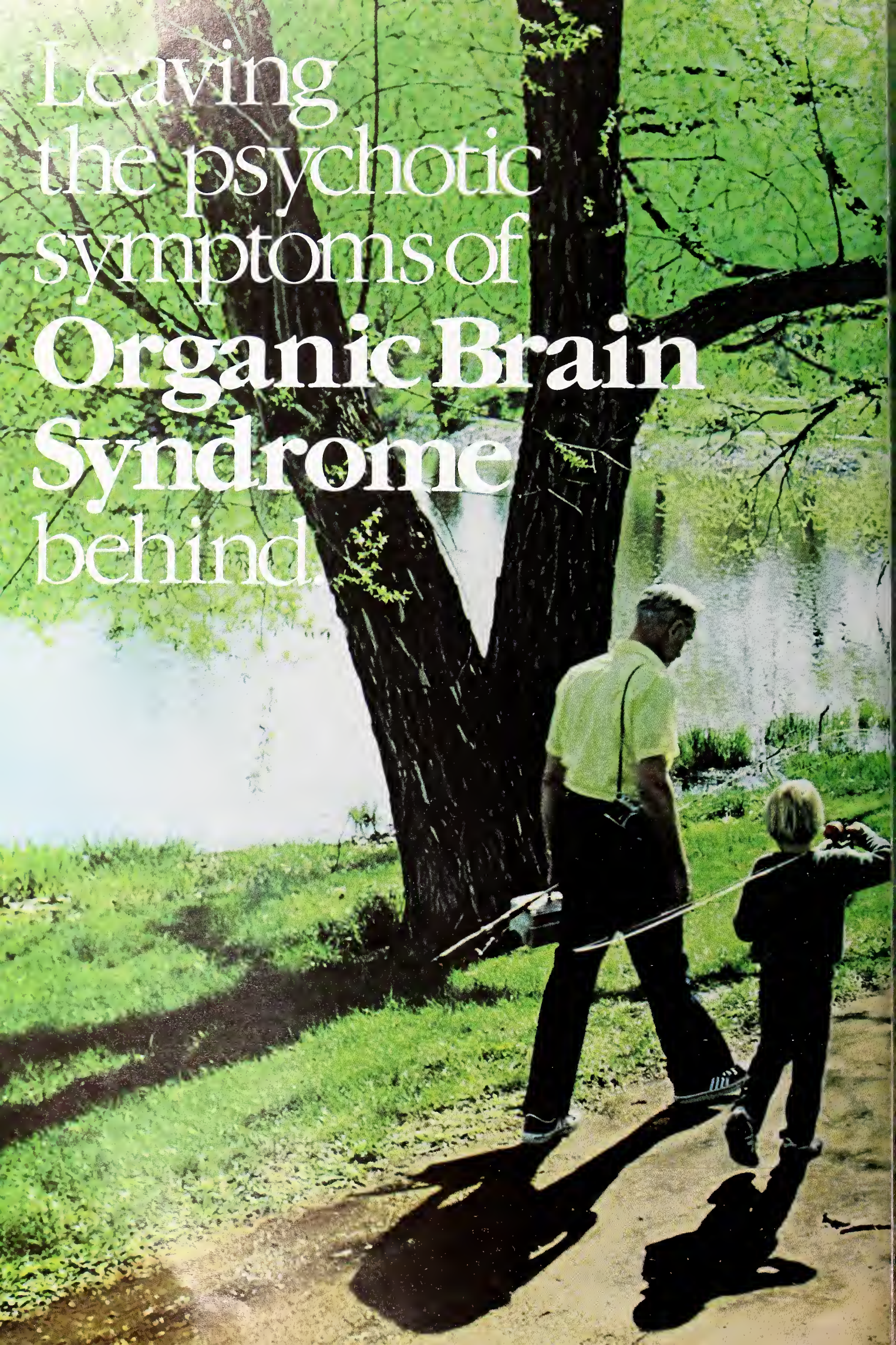
A child of an alcoholic is so filled with self-hate and resentment that he may suffer headaches and abdominal cramps, he may miss school, his grades may drop, or he may try suicide. How can a thinking person believe that it is the parent's problem and not that of the child?

If one really can buy the myth that a child from an alcoholic home will ask for help if he really wants it, then take a close look at the expression on the face of a kid from an alcoholic home. Look into his eyes and see the denial, the fears, and the held-back tears as he fights to hide the family secret. You will not see it if you do not ask the right question and look. How many of us do?

I may be overreacting to that list which incurred my wrath, but I know that a majority of physicians feel that dealing with alcoholism and the family is someone else's job. How can one who has taken the Hippocratic oath really avoid the cause of an incestual pregnancy or the brutal signs of child abuse?

The retreat behind the mythical wall that, somehow, alcoholism is a personal matter is to ignore the ugly alcohol-induced violence and the disastrous psychological effects on the family.

Society is calling for help—through television, radio, newspapers, magazines. We see messages to us, the members of the medical profession, to meet our obligations and fight the epidemic of alcohol and drug abuse. If our answer, due to whatever our excuse—prejudice, myths and fears—is in the negative, then to the shame of our profession, society will turn to others who already are doing and showing that they really care.


Leaving
the psychotic
symptoms of
Organic Brain
Syndrome
behind.



Effective

Treatment with Navane can produce improvement in psychotic symptoms such as hallucinatory behavior and unusual thought content as well as hostility, disorientation and depressive mood,[1,2] leaving the elderly patient more alert[2] and better able to participate in the activities of family life.

Well tolerated

Navane is generally well tolerated by elderly patients. Excessive sedation or drowsiness has been reported, but is uncommon.[1] Anticholinergic effects[3] and hypotension[4,5] are reported, but rarely. Should they occur, extrapyramidal symptoms can usually be readily controlled.

Navane®

(thiothixene) (thiothixene HCl)

Capsules 1 mg, 2 mg, 5 mg, 10 mg, 20 mg
Concentrate 5 mg/ml Intramuscular 2 mg/ml, 5 mg/ml

See following page for a brief summary of prescribing information.

© 1982, Pfizer Inc.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
at the forefront of psychopharmacology

Navane®
(thiothixene) (thiothixene HCl)

References 1. Util TM, Unverdi C, Wohlrade J, et al: Drug therapy of psychosis associated with organic brain syndrome. Presented as a Scientific Exhibit at the American Public Health Association Centennial, Atlantic City, New Jersey, November 12-16, 1972. 2. Katz MM, Util TM: Video methodology for research in psychopathology and psychopharmacology. *Arch Gen Psychiatry* 31:204-210, 1974. 3. Ketai R: Psychotropic drugs in the management of psychiatric emergencies. *Postgraduate Medicine* 58:87-93, 1975. 4. Birkett DP, Hirschfield W, Simpson GM: Thiothixene in the treatment of diseases of the senium. *Curr Ther Res* 14:775-779, 1972. 5. Data on file at Roerig.

BRIEF SUMMARY OF PRESCRIBING INFORMATION
Navane® (thiothixene) Capsules: 1 mg, 2 mg, 5 mg, 10 mg, 20 mg
(thiothixene hydrochloride) Concentrate: 5 mg/ml, Intramuscular: 2 mg/ml, 5 mg/ml
Contraindications: Navane (thiothixene) is contraindicated in patients with circulatory collapse, comatose states, central nervous system depression due to any cause, and blood dyscrasias. Navane is contraindicated in individuals who have shown hypersensitivity to the drug. It is not known whether there is a cross-sensitivity between the thioxanthenes and the phenothiazine derivatives, but the possibility should be considered.
Warnings: *Usage in Pregnancy*—Safe use of Navane during pregnancy has not been established. Therefore, this drug should be given to pregnant patients only when, in the judgment of the physician, the expected benefits from the treatment exceed the possible risks to mother and fetus. Animal reproduction studies and clinical experience to date have not demonstrated any teratogenic effects.

In the animal reproduction studies with Navane, there was some decrease in conception rate and litter size, and an increase in resorption rate in rats and rabbits, changes which have been similarly reported with other psychotropic agents. After repeated oral administration of Navane to rats (5 to 15 mg/kg/day), rabbits (3 to 50 mg/kg/day), and monkeys (1 to 3 mg/kg/day) before and during gestation, no teratogenic effects were seen. (See Precautions.)

Usage in Children—The use of Navane in children under 12 years of age is not recommended because safety and efficacy in the pediatric age group have not been established.

As is true with many CNS drugs, Navane may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery, especially during the first few days of therapy. Therefore, the patient should be cautioned accordingly.

As in the case of other CNS-acting drugs, patients receiving Navane should be cautioned about the possible additive effects (which may include hypotension) with CNS depressants and with alcohol.
Precautions: An antiemetic effect was observed in animal studies with Navane, since this effect may also occur in man, it is possible that Navane may mask signs of overdosage of toxic drugs and may obscure conditions such as intestinal obstruction and brain tumor.

In consideration of the known capability of Navane and certain other psychotropic drugs to precipitate convulsions, extreme caution should be used in patients with a history of convulsive disorders or those in a state of alcohol withdrawal since it may lower the convulsive threshold. Although Navane potentiates the actions of the barbiturates, the dosage of the anticonvulsant therapy should not be reduced when Navane is administered concurrently.

Caution as well as careful adjustment of the dosage is indicated when Navane is used in conjunction with other CNS depressants other than anticonvulsant drugs.

Though exhibiting rather weak anticholinergic properties, Navane should be used with caution in patients who are known or suspected to have glaucoma, or who might be exposed to extreme heat, or who are receiving atropine or related drugs.

Use with caution in patients with cardiovascular disease.

Also, careful observation should be made for pigmentary retinopathy, and lenticular pigmentation (fine lenticular pigmentation has been noted in a small number of patients treated with Navane for prolonged periods). Blood dyscrasias (agranulocytosis, pancytopenia, thrombocytopenic purpura), and liver damage (jaundice, biliary stasis) have been reported with related drugs.

Undue exposure to sunlight should be avoided. Photosensitive reactions have been reported in patients on Navane.

Neuroleptic drugs elevate prolactin levels; the elevation persists during chronic administration. Tissue culture experiments indicate that approximately one-third of human breast cancers are prolactin dependent *in vitro*, a factor of potential importance if the prescription of these drugs is contemplated in a patient with a previously detected breast cancer. Although disturbances such as galactorrhea, amenorrhea, gynecomastia, and impotence have been reported, the clinical significance of elevated serum prolactin levels is unknown for most patients. An increase in mammary neoplasms has been found in rodents after chronic administration of neuroleptic drugs. Neither clinical studies nor epidemiologic studies conducted to date, however, have shown an association between chronic administration of these drugs and mammary tumorigenesis; the available evidence is considered too limited to be conclusive at this time.

Intramuscular Administration—As with all intramuscular preparations, Navane Intramuscular should be injected well within the body of a relatively large muscle. The preferred sites are the upper outer quadrant of the buttock (i.e. gluteus maximus) and the mid-lateral thigh.

The deltoid area should be used only if well developed, such as in certain adults and older children, and then only with caution to avoid radial nerve injury. Intramuscular injections should not be made into the lower and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.
Adverse Reactions: *Note:* Not all of the following adverse reactions have been reported with Navane (thiothixene). However, since Navane has certain chemical and pharmacologic similarities to the phenothiazines, all of the known side effects and toxicity associated with phenothiazine therapy should be borne in mind when Navane is used.

Cardiovascular effects: Tachycardia, hypotension, lightheadedness, and syncope. In the event hypotension occurs, epinephrine should not be used as a pressor agent since a paradoxical further lowering of blood pressure may result. Nonspecific EKG changes have been observed in some patients receiving Navane. These changes are usually reversible and frequently disappear on continued Navane therapy. The incidence of these changes is lower than that observed with some phenothiazines. The clinical significance of these changes is not known.

CNS effects: Drowsiness, usually mild, may occur although it usually subsides with continuation of Navane therapy. The incidence of sedation appears similar to that of the piperazine group of phenothiazines, but less than that of certain aliphatic phenothiazines. Restlessness, agitation and insomnia have been noted with Navane (thiothixene). Seizures and paradoxical exacerbation of psychotic symptoms have occurred with Navane infrequently.

Hyperreflexia has been reported in infants delivered from mothers having received structurally related drugs.

In addition, phenothiazine derivatives have been associated with cerebral edema and cerebrospinal fluid abnormalities.

Extrapyramidal symptoms, such as pseudo-parkinsonism, akathisia, and dystonia have been reported. Management of these extrapyramidal symptoms depends upon the type and severity. Rapid relief of acute symptoms may require the use of an injectable antiparkinson agent. More slowly emerging symptoms may be managed by reducing the dosage of Navane and/or administering an oral antiparkinson agent.

Persistent Tardive Dyskinesia: As with all antipsychotic agents tardive dyskinesia may appear in some patients on long term therapy or may occur after drug therapy has been discontinued. The risk seems to be greater in elderly patients on high-dose therapy, especially females. The symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Sometimes these may be accompanied by involuntary movements of extremities.



There is no known effective treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms of this syndrome. It is suggested that all antipsychotic agents be discontinued if these symptoms appear.

Should it be necessary to reinstitute treatment, or increase the dosage of the agent, or switch to a different antipsychotic agent, the syndrome may be masked.

It has been reported that fine vermicular movements of the tongue may be an early sign of the syndrome and if the medication is stopped at that time, the syndrome may not develop.

Hepatic effects: Elevations of serum transaminase and alkaline phosphatase, usually transient, have been infrequently observed in some patients. No clinically confirmed cases of jaundice attributable to Navane (thiothixene) have been reported.

Hematologic effects: As is true with certain other psychotropic drugs, leukopenia and leukocytosis, which are usually transient, can occur occasionally with Navane. Other antipsychotic drugs have been associated with agranulocytosis, eosinophilia, hemolytic anemia, thrombocytopenia and pancytopenia.

Allergic reactions: Rash, pruritus, urticaria, photosensitivity and rare cases of anaphylaxis have been reported with Navane. Undue exposure to sunlight should be avoided. Although not experienced with Navane, exfoliative dermatitis and contact dermatitis (in nursing personnel) have been reported with certain phenothiazines.

Endocrine disorders: Lactation, moderate breast enlargement and amenorrhea have occurred in a small percentage of females receiving Navane. If persistent, this may necessitate a reduction in dosage or the discontinuation of therapy. Phenothiazines have been associated with false positive pregnancy tests, gynecomastia, hypoglycemia, hyperglycemia, and glycosuria.

Autonomic effects: Dry mouth, blurred vision, nasal congestion, constipation, increased sweating, increased salivation, and impotence have occurred infrequently with Navane therapy. Phenothiazines have been associated with miosis, mydriasis, and adynamic ileus.

Other adverse reactions: Hyperpyrexia, anorexia, nausea, vomiting, diarrhea, increase in appetite and weight, weakness or fatigue, polydipsia and peripheral edema.

Although not reported with Navane, evidence indicates there is a relationship between phenothiazine therapy and the occurrence of a systemic lupus erythematosus-like syndrome.

NOTE: Sudden deaths have occasionally been reported in patients who have received certain phenothiazine derivatives. In some cases the cause of death was apparently cardiac arrest or asphyxia due to failure of the cough reflex. In others, the cause could not be determined nor could it be established that death was due to phenothiazine administration.
Dosage and Administration: Dosage of Navane should be individually adjusted depending on the chronicity and severity of the condition. In general, small doses should be used initially and gradually increased to the optimal effective level, based on patient response.

Some patients have been successfully maintained on once-a-day Navane therapy.

Usage in children under 12 years of age is not recommended because safe conditions for its use have not been established.

Navane Intramuscular Solution: Navane For Injection—Where more rapid control and treatment of acute behavior is desirable, the intramuscular form of Navane may be indicated. It is also of benefit where the very nature of the patient's symptomatology, whether acute or chronic, renders oral administration impractical or even impossible.

For treatment of acute symptomatology or in patients unable or unwilling to take oral medication, the usual dose is 4 mg of Navane Intramuscular administered 2 to 4 times daily. Dosage may be increased or decreased depending on response. Most patients are controlled on a total daily dosage of 16 to 20 mg. The maximum recommended dosage is 30 mg/day. An oral form should supplant the injectable form as soon as possible. It may be necessary to adjust the dosage when changing from the intramuscular to oral dosage forms. Dosage recommendations for Navane (thiothixene) Capsules and Concentrate appear in the following paragraphs.

Navane Capsules: Navane Concentrate—In milder conditions, an initial dose of 2 mg three times daily. If indicated, a subsequent increase to 15 mg/day total daily dose is often effective.

In more severe conditions, an initial dose of 5 mg twice daily.

The usual optimal dose is 20 to 30 mg daily. If indicated, an increase to 60 mg/day total daily dose is often effective. Exceeding a total daily dose of 60 mg rarely increases the beneficial response.
Overdosage: Manifestations include muscular twitching, drowsiness, and dizziness. Symptoms of gross overdosage may include CNS depression, rigidity, weakness, torticollis, tremor, salivation, dysphagia, hypotension, disturbances of gait, or coma.

Treatment: Essentially is symptomatic and supportive. For Navane oral, early gastric lavage is helpful. For Navane oral and Intramuscular, keep patient under careful observation and maintain an open airway, since involvement of the extrapyramidal system may produce dysphagia and respiratory difficulty in severe overdosage. If hypotension occurs, the standard measures for managing circulatory shock should be used (I.V. fluids and/or vasoconstrictors.)

If a vasoconstrictor is needed, levarterenol and phenylephrine are the most suitable drugs. Other pressor agents, including epinephrine, are not recommended, since phenothiazine derivatives may reverse the usual pressor action of these agents and cause further lowering of the blood pressure.

If CNS depression is present and specific therapy is indicated, recommended stimulants include amphetamine, dextroamphetamine, or caffeine and sodium benzoate. Stimulants that may cause convulsions (e.g. picrotoxin or pentylenetetrazol) should be avoided. Extrapyramidal symptoms may be treated with antiparkinson drugs.

There are no data on the use of peritoneal or hemodialysis, but they are known to be of little value in phenothiazine intoxication.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals

Should Certificate of Need Legislation Be Repealed?

VINCENT A. MARESSA, J.D.

Health service researchers have begun to question the assumptions underlying the certificate of need concept. New Jersey is seriously considering expanding its certificate of need law to remove the current exemption granted to physicians in their private practices.

Certificate of need laws were designed to combat spiraling health care costs and the unnecessary duplication and maldistribution of health care facilities and services. Health service researchers in several disciplines have begun to question many of the assumptions underlying the certificate of need concept. While this is occurring, New Jersey which has a penchant for being different is seriously considering expanding its certificate to need law to remove the current exemption granted physicians in their private practices. The Blue Ribbon Committee to the State Health Coordinating Council has recommended this action without any objective documentation of its advisability, or for that matter a clear understanding of the problem.

The Utah Law Review, Volume 1978, Number 1, published by the University of Utah College of Law contains a series of papers on the certificate of need mechanism.

The first paper presents an overview and was written by James F. Blumstein, Professor of Law, Vanderbilt Law School and Frank A. Sloan, Professor of Economics, Vanderbilt University. The work on the article was supported in part by the Vanderbilt Institute for Public Policy Studies and by Grant No. 7-RO1-HS 02590 from the National Center for Health Services Research, United States Department of Health and Human Services.

The authors begin by citing a number of defects in our health care system which led to increased costs. They then point out that while the defects are widely recognized, not all agree the solution is to impose rationing on the health "nonsystem" through a centralized bureaucratic system of controls. They indicate that the research community interested in the effects of certificate of need legislation has developed and sought the answers to a series of questions. They state that research findings on the effects of certificate of need must be considered very tentative and often are contradictory.

They conclude by stating, "While we are forced to hedge somewhat since some indepth research is still in progress, it is fairly safe to conclude that the certificate of need review will at best make a minor contribution to tempering the rate of rising health care costs. . . . Moreover, the certificate of need may not turn out to achieve the cost-containment objectives its proponents had anticipated."

It is this writer's belief that the predictions of Blumstein and Sloan published in 1978 have indeed come to pass. The Health Department in New Jersey recognizes that the certificate of need has not delivered what was promised. It, however, believes the solution rests in expansion of jurisdiction. On the other hand, the Commissioner of Health declared on October 25, 1983, that New Jersey has 30 percent more acute hospital beds than it needs. If the certificate of need process held any promise, it was in controlling the number of hospitals beds. As the Commissioner indicated, it has been a dismal failure in that regard.

Certainly, it is time for hospital governing boards, hospital management, the medical community, and the patient population to re-evaluate the certificate of need concept and to make their views known to the Department of Health and the legislature. The Department should conduct some serious introspective reflection to ascertain what purpose has been served by the certificate of need exercise other than the employment of planners.

*The material for this column is coedited by Arthur Krosnick, M.D., Editor, *The Journal*, MSNJ; Vincent A. Maressa, J.D., Executive Director, MSNJ; and James E. George, M.D., J.D., Director of Professional Liability, MSNJ.

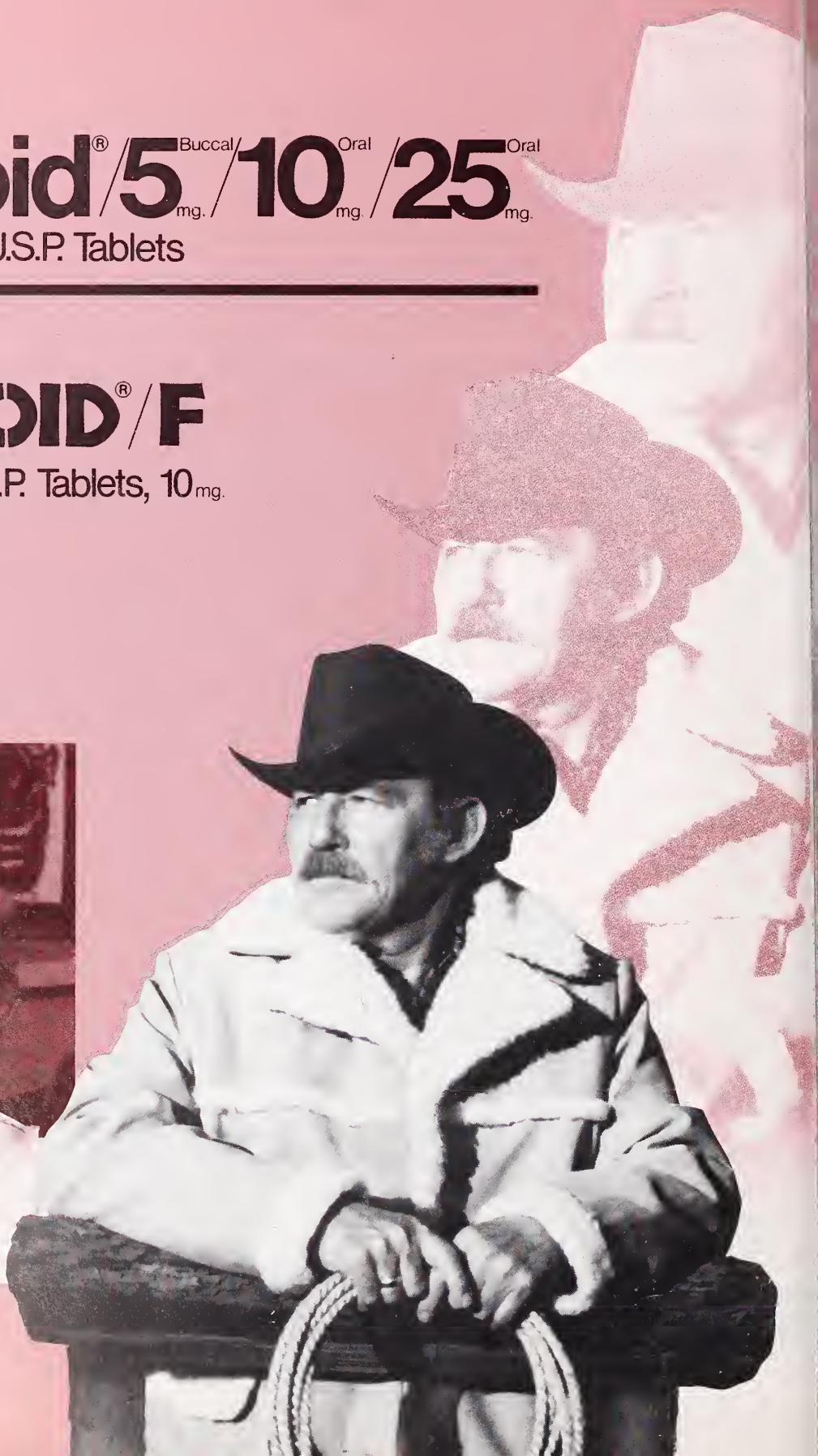
THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR.

Android®/5 mg. Buccal/10 mg. Oral/25 mg. Oral
Methyltestosterone U.S.P. Tablets

ANDROID®/F
Fluoxymesterone U.S.P. Tablets, 10 mg.





Psychological Effects of Rhinoplasty

Alvin I. Glasgold, M.D., and Susan B. Horowitz, Ph.D., New Brunswick

Assessing the psychological and social consequences of rhinoplasty, 139 patients were mailed questionnaires to measure change in three areas: attitudes towards physical appearance, self-esteem, and social relationships. A majority of patients reported increased self-esteem and improved attitudes.

A recent article in the science section of *The New York Times* indicated that attractive people are perceived as more poised, sensitive, sincere, intelligent, and successful than others.[1] Along with the recent increase in publicity about cosmetic surgery, this would tend to reinforce the positive value of this type of surgery. If this is true, do people who undergo a change in appearance equally change in a positive psychological sense? Are they perceived differently? Do they make social gains? Do they change in their relationships to friends and family?

Since the 1940s, numerous studies have focused on the motivations and characteristics of individuals seeking rhinoplasty. Several researchers report a high degree of emotional disturbance among the population seeking rhinoplasty.[2-4] A common psychiatric viewpoint, based on unconscious conflict and symptom substitution, suggests that rhinoplasty is likely to have an unpredictable, negative psychological effect or, at best, no effect at all.[5-7] In May 1980, Shulman discussed assessment of the prospective rhinoplasty patient in terms of psychopathology, emphasizing the need for routine psychiatric screening.[7]

Researchers may have been overly concerned with documenting the motivations and psychiatric symptomatology of candidates for rhinoplasty as opposed to focusing on the psychological and social gains actually made following surgery. This study considers the question of positive psychological change which follows cosmetic rhinoplasty. The researchers attempt to answer the following questions: Are patients satisfied with the results of their surgery? Are there specific psychological changes in patients following rhinoplasty? What is the significance of the patient's preoperative expectations?

METHODS

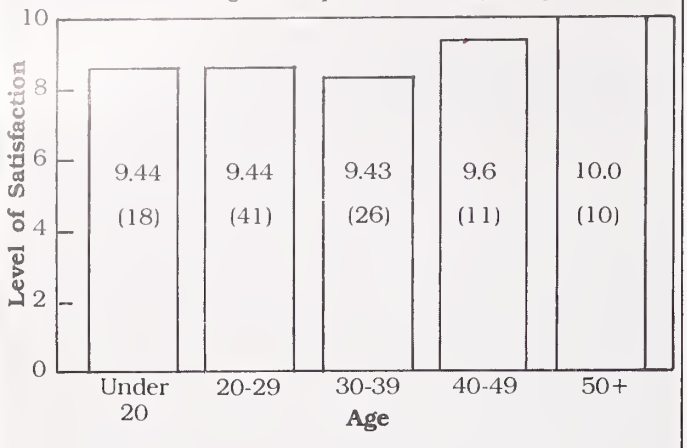
In April 1979, questionnaires were mailed to 254 former patients who had rhinoplasty operations between September 1976 and September 1978. Completed questionnaires were received from 106 patients. A random sample of 33 patients who did not respond to the mailed questionnaire were contacted by phone. Their responses were similar to the larger sample who responded to mailed questionnaires.

The total sample consisted of 139 patients (31 men and 108 women) ranging in age from 15 to 57 years old. At least six months elapsed between a patient's rhinoplasty and the arrival of the questionnaire. This

*Dr. Glasgold is Chairman, Department of Otolaryngology-Head and Neck Surgery, St. Peter's Medical Center and Middlesex General-University Hospital, New Brunswick. Dr. Horowitz is affiliated with Rutgers University, Graduate School of Social Work, New Brunswick. Correspondence may be addressed to Dr. Glasgold, 31 River Road, Highland Park, NJ 08904.

TABLE 1

Average Levels of Satisfaction for Age Group with Rhinoplasty



n=106
0=Minimum level of satisfaction
10=Maximum level of satisfaction

timing deliberately was designed to give patients ample time to resume their personal lives following surgery and for postoperative swelling to diminish. Patients who explained that their rhinoplasty was due to trauma or breathing difficulty, denying cosmetic motivation, were eliminated from the study.

THE QUESTIONNAIRE

The questionnaire focused on three areas: patient satisfaction with the results of rhinoplasty; level of psychological change following rhinoplasty; and patient expectations prior to rhinoplasty surgery.

In order to measure satisfaction with rhinoplasty, patients were asked to rate their level of satisfaction with cosmetic results on a 0 to 10 point scale. To measure the level of psychological change following rhinoplasty, 15 questions were used to assess a given patient's attitude towards appearance, sense of self-esteem, and behavior in social situations. The average of changes in these three areas is referred to as a patient's psychological change score.

Patient expectations prior to rhinoplasty were assessed in two ways: in terms of psychological expectations dealing with possible differences in a person's feeling of attractiveness, popularity, self-confidence and social relationships which might take place following rhinoplasty, and physical expectations aimed specifically at the patient's imagined idea of what the face and nose would like following surgery. A 0 to 10 point scale again was utilized to measure both levels of expectations.

ANALYSIS OF DATA

The first factor that was analyzed was patient satisfaction with the results of rhinoplasty.

Data analysis revealed that an overwhelming majority of patients were very satisfied with the results of rhinoplasty. On a 0 to 10 point scale where 10 represents maximum satisfaction with results, the mean level of patient satisfaction was 9.5 with the modal (most frequent) response being 10.

Although we expected responses indicating general satisfaction, we were surprised by the high level of satisfaction. Table 1 indicates a breakdown according to age with some slight increase in satisfaction in the older age group. Because of the almost universal response, further demographic breakdown was not indicated.

In order to test the hypothesis that positive psychological change takes place following rhinoplasty, the psychological change scores of patients were analyzed. Three specific areas of change were identified: improvements in attitudes towards physical appearance; improvements in self-esteem; and improvements in social relationships.

Using statistical analysis (t tests and ANOVA), age was found to be a significant variable ($P<.03$) particularly in the area of improved social relationships. Younger patients, specifically under age 30, demonstrated greater gains in social relationships following rhinoplasty than did older patients. The 15- to 19-year-old age group showed the greatest gain in this area.

Table 2 shows that the greatest positive psychological change occurs with respect to patients' attitudes towards their physical appearance. This is true for all age categories.

Moderate improvements in self-esteem and social relationships also take place for all age groups. It should be noted that the youngest age group, 15 to 19 years old, made the greatest improvements in all three areas of psychological change following rhinoplasty.

Table 3 considers the psychological and physical expectations of rhinoplasty patients before their surgery.

As a group, prospective rhinoplasty patients had moderately low expectations for psychological change following their surgery. It should be noted here that age is a significant variable in this ($P<.02$) indicating that the younger patients showed higher levels or projected changes in their lives as a consequence of rhinoplasty. Again, the 15- to 19-year-old age group showed the highest level of psychological expectations as to possible life changes following surgery.

Items labeled as physical expectations refer to the patient's expectation of what the face and nose would actually look like after rhinoplasty. Data revealed that most patients did not expect to look perfect and most had no specific or rigid idea of what their nose would look like before surgery. This was true for all patients with no significant difference noted for any age group.

The fact that the youngest group of patients had the highest psychological expectations for their rhinoplasty is interesting in light of the previous findings that the younger group actually accomplished the greatest psychologic gains in all areas tested, namely attitude towards appearance, self-esteem, and social relationships. It appears that younger patients who have moderately high expectations prior to rhinoplasty, as a group, follow through after surgery to make significant positive psychological gains.

When a patient's psychological expectations were correlated with total psychological change scores following rhinoplasty, r=.66. In other words, moderately high patient expectations prior to rhinoplasty may be related to actual level of change following surgery. Perhaps the traditional viewpoint of skeptically viewing high patient expectations as an indicator of potential patient dissatisfaction needs to be seriously challenged.

TABLE 2

Average Psychological Change Scores for Age Groups

	Age (18) 15 to 19	(41) 20 to 29	(26) 30 to 39	(11) 40 to 49	(10) 50+	Total
Physical Appearance	8.5	7.1	7.5	6.5	7.4	7.4
Self-Esteem	7.3	5.6	6.2	5.1	5.3	6.0
Social Relationships	7.5	4.7	5.2	4.4	4.1	5.2
(Average) Psychological Change Score	7.7	5.8	6.3	5.3	5.6	6.2

n=106
0=Minimum level of satisfaction
10=Maximum level of satisfaction

TABLE 3

Average Expectations and Age Levels of Rhinoplasty Patients Before Surgery

Age	Psychological Expectation Level	Physical Expectation Level
Under 20	5.6	4.5
20 to 29	3.3	5.6
30 to 39	3.3	3.7
40 to 49	3.9	5.7
50+	2.5	3.8
Average	3.7	4.8

0=Minimum level of expectation
10=Maximum level of expectation

CONCLUSIONS

This study tests the hypothesis that there is positive psychological change following cosmetic rhinoplasty. Data indicate that patients do make moderate gains in three areas. The most outstanding changes are in attitudes towards physical appearance, but there are moderate gains made in self-esteem and social relationships as well.

It is significant that the younger age group achieved the greatest changes. This indicates the importance of establishing a positive physical self-image during the period of emotional and social maturation. The fact that the older age group achieved some changes suggests the importance of the role of physical appearance throughout life.

With respect to the level of psychological expectations prior to rhinoplasty, age was a significant variable. Younger patients had higher expectations of projected social and psychological changes in their lives prior to rhinoplasty. High expectations prior to rhinoplasty were correlated positively with the actual level of psychological change taking place following surgery. The younger patient who has fairly high hopes following rhinoplastic surgery does in fact achieve this change in self-image, as does the older patient to a somewhat lesser degree. Furthermore, this suggests that the patient with a high expectation level necessarily is not an added risk in terms of dissatisfaction with results.

In view of the literature focusing on patient personality disorders, the fact that we noted such a high level of patient satisfaction is encouraging, particularly in that there was no preoperative psychological evaluation of these patients beyond the routine consultation.

In summary, the overwhelming majority of patients sampled in this study were subjectively satisfied with their results. Given patient satisfaction, significant psychological and social changes do take place following rhinoplasty particularly in the younger age group. Attitudes toward physical appearance are enhanced greatly for all patients with moderate improvements in self-esteem and social relationships as well.

REFERENCES

1. Brody E: Effects of beauty found to run surprisingly deep. *The New York Times:* C1-C3, 1981.
2. Linn L, Goldman IB: Psychiatric observations concerning rhinoplasty. *Psychosom Med* 41:307-314, 1949.
3. Edgerton M, Jacobson W, Meyer E: Surgical-psychiatric study of patients seeking plastic surgery. *Br Plastic Surg* 13:279-281, 1960.
4. Hay GG: Pyschiatric aspects of cosmetic nasal operations. *Am J Psych* 116:85-97, 1970.
5. Jacobson W, Edgerton M, Meyer E, Psychiatric evaluation of male patients seeking cosmetic surgery. *Plast Reconstr Surg* 25:356-373, 1960.
6. Hill G, Silver AG, Edgerton M: Psychodynamic and aesthetic motivations for plastic surgery. *Psychosom Med* 14:345-356, 1950.
7. Shulman H: Psychiatric assessment of the candidate for cosmetic surgery. *Otolaryngol Clin North Am* 12:383-389, 1980.

Radionuclide Testicular Scanning

John L. McCormack, M.D., Long Branch*

Thirty-two patients underwent testicular scanning with ^{99m}technetium pertechnetate. Results compare favorably with the literature. This radiographic technique is a reliable means to evaluate the patient with testicular pain.

Numerous studies in surgical, pediatric, and nuclear medicine literature have shown radionuclide scanning of the scrotum to be a safe, effective, and relatively noninvasive technique of evaluating the male patient with testicular pain. The studies have demonstrated that in the patient with equivocal findings on physical and laboratory examination, dynamic and static scanning with ^{99m}technetium pertechnetate reliably can differentiate between conditions requiring surgical intervention and those amenable to medical therapy.[1-6] Our experience at Monmouth Medical Center, Long Branch, is consistent with these results.

METHODS

Patients assume a supine position under a single crystal gamma camera with pinhole collimation. A bolus of ^{99m}technetium pertechnetate is injected intravenously in a dose ranging from 8 to 10 mCi (296 to 370 MBq), depending on the patient's weight. Dynamic scanning of the inguinal region is performed, obtaining sequential two-second images for a total of 2 minutes. A lead drape then is placed under the scrotum to shield out thigh activity: anterior static images are obtained at 5, 10, and 15 minutes after injection of the radiopharmaceutical. Simultaneous acquisition of the data by a General Electric computer provides a means of quantitatively analyzing the radioactivity within the scrotum.

RESULTS

Patterns of activity within the scrotum have been well described in the literature for various conditions.[2,4,6,7] Normally, blood flow to the scrotum as seen on dynamic scanning is symmetrical from side to side as is the activity within the scrotum on static imaging (Figure 1). Inflammatory processes such as epididymitis and orchitis are associated with unilaterally increased activity on the affected side on both dynamic and static images (Figure 2). An acute testicular torsion will result in decreased activity on the affected side on both phases of the scan (Figure 3A). Other conditions requiring surgical treatment such as testicular torsion of several days duration ("missed" testicular torsion) and scrotal abscess may show increased activity on the affected side during the dynamic study, whereas static images generally will show a peripheral rim of increased activity surrounding an area of abnormally low activity in that side of the scrotum (Figures 3B, 3C, and 4). A similar pattern has been described related to testicular rupture following blunt scrotal trauma.[8]

*From the Department of Diagnostic Radiology, Monmouth Medical Center, Long Branch. Correspondence may be addressed to Dr. McCormack, Department of Diagnostic Radiology, Monmouth Medical Center, 300 Second Avenue, Long Branch, NJ 07740.

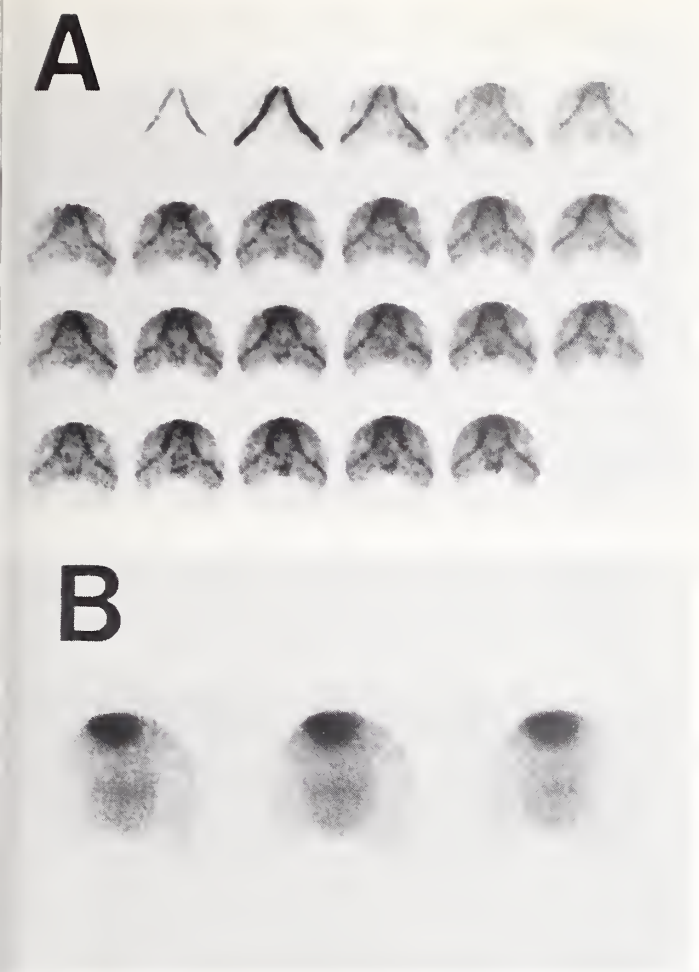


Figure 1—Normal ^{99m}technetium pertechnetate testicular scan; **A:** dynamic images, and **B:** static images.

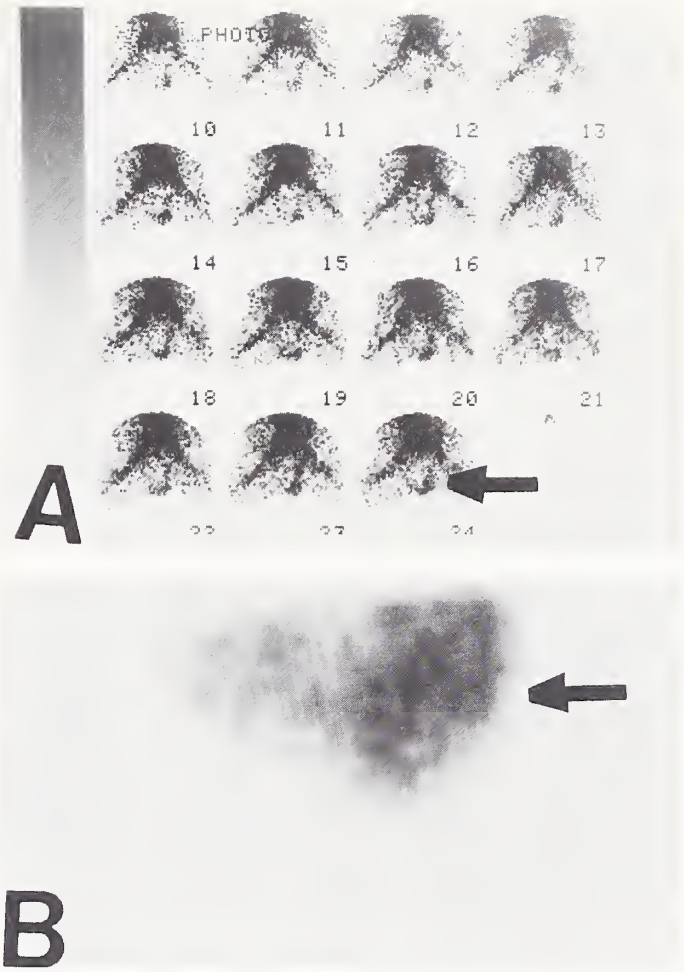


Figure 2—Increased activity on left side of scrotum (arrows) on both dynamic **(A)** and static **(B)** images: inflammatory process.

TABLE

Results of ^{99m}Technetium Pertechnetate Testicular Scanning: Monmouth Medical Center November 1980-December 1982

Scan Findings	No. of Patients	Clinical Outcome
No asymmetry in activity	3	2 recovered with medical therapy 1 torsed viable testicle at surgery
Increased activity affected side on static and dynamic images	19	All recovered with medical therapy
Decreased activity affected side on static and dynamic images	2	1 torsed viable testicle at surgery 1 torsed necrotic testicle, orchiectomy
Rim of increased activity, central decreased activity on affected side, static and dynamic or static alone	4	2 torsed necrotic testicle, orchiectomy 1 torsed viable testicle 1 no information available
Minimal decreased activity on affected side static and/or dynamic images	4	1 torsion of appendix testis at surgery 1 incomplete testicular torsion at surgery 1 benign inflammatory cyst with hemorrhage 1 no information available



Figure 3A—Patient presented with acute onset of left testicular pain; initial static images reveal decreased activity on left side of scrotum (arrow). Surgery is not performed immediately due to suspicion of undescended left testicle as cause of asymmetrical activity.



Figure 3B—Same patient underwent repeat scan three days after initial study; rim of increase activity after central areas of decreased activity noted on left (arrow). Torsed but viable testicle found at surgery.



Figure 3C—Followup scan eight weeks after surgery revealed symmetrical activity.

From November 1980 through December 1982, 32 patients underwent radionuclide testicular scanning at Monmouth Medical Center. Of these studies, 19 were indicative of an inflammatory process; all of these patients were successfully treated medically as in- or outpatients, and none required surgery. Two patients who had normal scans were managed conservatively.

The scans of six patients unequivocally demonstrated conditions that necessitated surgery. Each of two patients was found to have a torsed but viable testicle at surgery. In each of the three patients, a necrotic testicle was discovered resulting in unilateral orchiectomy. Information on one patient was unavailable.

Five other patients demonstrated a variety of findings. Scanning was normal on one patient who, due to clinical findings and the absence of signs of an inflammatory process on the radionuclide study, was taken to surgery where a torsed but viable testicle was found. Minimal asymmetry in activity was noted on scanning the other four patients in this group, all of

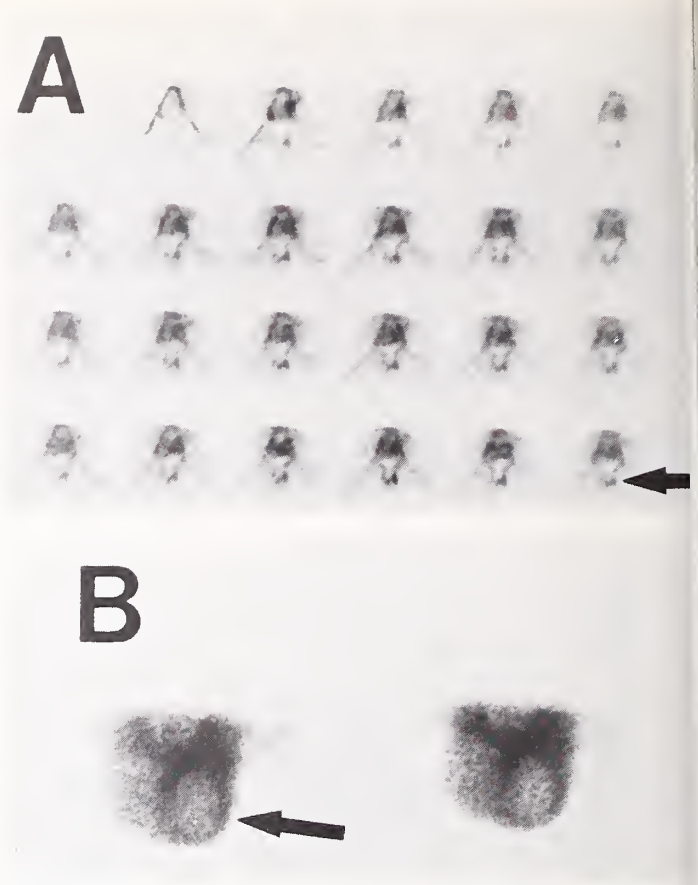


Figure 4—Increased flow to left side of scrotum on dynamic **(A)** imaging in a patient treated for inflammatory process for four days based on physical and laboratory findings. Central decreased activity noted on left with rim of increased activity on static images **(B)** (arrows). Necrotic left testicle removed at surgery.

whom subsequently underwent surgery. One patient had torsion of the appendix testis; another had an incomplete testicular torsion; in a third patient, a benign inflammatory cyst was encountered that had hemorrhaged. Information on the fourth patient was unavailable (Table).

DISCUSSION

Clinical differentiation of acute testicular torsion, as well as other surgical conditions affecting the testes and scrotum, from medically treatable illnesses can be difficult. While fever, leukocytosis, and pyuria are considered more likely to indicate inflammatory process, these signs will not exclude the presence of scrotal abscess. Furthermore, the signs noted above do not necessarily exclude testicular torsion.[4,9,10] While torsion occurs most commonly between the ages of 12 and 18 years, it has been described in patients aged 68 years.[9-11] Physical examination may yield ambiguous results and may be quite difficult to perform owing to the pain and tenderness which may accompany either an inflammatory process or acute torsion.[4,11]

Testicular blood flow has been studied by means of the Doppler ultrasonic flowmeter in order to diagnose acute testicular torsion without an invasive procedure. However, this method has not proved as reliable in differentiating acute torsion from other conditions associated with scrotal pain and is unable to distinguish medically treatable causes of scrotal

hyperemia from those requiring surgery.[3,12-14] As described previously, radionuclide scanning can make this distinction.

Early diagnosis, particularly in the case of acute testicular torsion, is imperative to preserve testicular function. Absence of spermatogenesis has been demonstrated experimentally after four hours of complete ischemia; Sertoli and Leydig cells appear somewhat more resistant to the effects of ischemia.[15] Overall, testicular viability has been reported to be 80 to 100 percent when torsion is corrected within six hours of the onset of symptoms.[16] Furthermore, as the anatomic defect allowing the testicle to twist is bilateral in the majority of cases, identification of the patient with torsion indicates the need for surgical fixation of the nontorsed testicle.[10,11] Obviously, radionuclide scan evidence of a nonsurgical disorder precludes surgical exploration in the patient in whom this is unnecessary.

SUMMARY

Dynamic and static imaging of the scrotum with ^{99m}technetium pertechnetate is an effective means of evaluating the patient with acute scrotal pain. In the patient in whom the physical and laboratory examinations are equivocal, radionuclide scanning may differentiate conditions requiring surgery from those amenable to medical therapy. Rapid identification and surgical correction of acute testicular torsion is necessary to preserve testicular function, while patients with uncomplicated inflammatory conditions, such as epididymitis and orchitis, should not be subjected to surgery in order to rule out torsion as the etiology of their symptoms. Therefore, radionuclide testicular scanning should be performed in suspect cases emergently. When the study is not available on such a basis, patients immediately should be referred to an institution where this study can be performed as early as possible.

REFERENCES

1. Hahn LC, Nadel NS, Gitter NH, Vernon AR: Testicular scanning: A new modality for the preoperative diagnosis of testicular torsion. *J Urol* 113:60-62, 1975.

2. Boedecker RA, Sty JR, Jona LZ: Testicular scanning as a diagnostic aid in evaluating scrotal pain. *J Pediatrics* 94:760-762, 1979.

3. Smith SP, King LR: Torsion of the testis: Techniques of assessment. *Urol Clin North Am* 6:429-443, 1979.

4. Stage KH, Schoenvogel R, Lewis S: Testicular scanning: Clinical experience with 72 patients. *J Urol* 125:334-337, 1975.

5. Vordermark JS, Buck AS, Brown SR, Tuttle WK: The testicular scan: Use in diagnosis and management of acute epididymitis. *JAMA* 245:2512-2514, 1981.

6. Thomas WEG, Cooke PH, Davies ER, Jackson PC, Williamson RCN: Dynamic radionuclide scanning of the testis in acute scrotal conditions. *Br J Surg* 68:621-624, 1981.

7. Datta NS, Mishkin FS: Radionuclide imaging in intrascrotal lesions. *JAMA* 231:1060-1062, 1975.

8. McConnell JD, Peters PC, Lewis SE: Testicular rupture in blunt scrotal trauma: Review of 15 cases with recent application of testicular scanning. *J Urol* 128:309-311, 1982.

9. Altaffer LF: Testicular torsion in men. *J Urol* 123:37-38, 1980.

10. Ransler CW, Allen TD: Torsion of the spermatic cord. *Urol Clin North Am* 9:245-250, 1982.

11. Williamson RCN: Torsion of the testis and allied conditions. *Br J Surg* 63:465-476, 1976.

12. Rodriguez DD, Rodriguez WC, Rivera JJ, Rodriguez S, Otero AA: Doppler ultrasound versus testicular scanning in the evaluation of the acute scrotum. *J Urol* 125:343-346, 1981.

13. Iuchtman M, Zoireff L, Assa J: Doppler flowmeter in the differential diagnosis of the acute scrotum in children. *J Urol* 121:221-222, 1979.

14. Nasrallah PF, Manzone D, King LR: Falsely negative Doppler examinations in testicular torsion. *J Urol* 118:194-195, 1977.

15. Atallah MW, Mazzarino AF, Horton BF: Testicular scan, diagnosis and followup for torsion of testis. *J Urol* 118:120-121, 1977.

16. Cattolica EV, Karol JB, Rankin KN, Klein RS: High testicular salvage rate in torsion of the spermatic cord. *J Urol* 128:66-68, 1982.

Just once each day...

First-step blood pressure control with optimal simplicity

Benefits diuretics cannot offer ... Once-daily INDERAL LA (propranolol HCl) provides smooth, 24-hour control of blood pressure plus the cardiovascular benefits of the world's leading beta blocker. And INDERAL LA provides a high degree of patient acceptance—without potassium problems.

Experience no other beta blocker can match... Once-daily INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.



Start with 80 mg once daily... Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



80 mg 120 mg 160 mg

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

Just once each day for initial therapy in hypertension.

Ayerst®

Just once each day for initial therapy in HYPERTENSION.

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly hydrolyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

8950/284

Ayerst® AYERST LABORATORIES
New York, N.Y. 10017

Evaluation of the Suicidal Adolescent Patient Admitted to an Urban Hospital

Sophie Pierog, M.D., and Austin Hill, Ph.D., Jersey City*

Suicide is a frequent cause of death in adolescence, but the number of suicide gestures exceeds successful suicide. We reviewed the suicide experience; patients were studied as to method and lethality of attempt and psychotherapy. Treatment in a general pediatric/adolescent hospital ward was safe and efficacious.

Suicide is reported as a frequent cause of death in adolescence. Since the number of successful suicides among adolescents reflects only 0.5 to 1.0 percent of the actual attempts, it is obvious that this represents a substantial problem in pediatric/adolescent medicine.[1] Ravenhorst estimated that suicidal attempts in an urban population may account for some 12 percent of all emergency room visits.[2] Suicide "gestures" as compared to successful suicides have been reported at a ratio of 50 to 120 to 1, indicating that this method may be used as a "cry for help" by the teenager who is not mentally disturbed but in desperate need for adult (societal) attention.[3] Marks, acting on this premise, safely hospitalized her suicidal adolescents on a general ward to provide a separation from the stresses in the environment which triggered the suicidal act.[4]

At Jersey City Medical Center, we decided that all adolescents and preadolescents with a history of attempted suicide automatically would be admitted to the general pediatric/adolescent service. The purposes of our year-long study were: to evaluate such patients as to their ethnic background, family background, and personal psychopathology and the method and lethality of the attempt; and to determine the safety and efficacy of admitting these patients to a general, open ward service by comparing our data to Marks.[4]

METHOD

The pediatric/adolescent department at the Jersey City Medical Center admits patients up to and including the age of 15. All adolescents and preadolescents who came or were brought to the emergency room or to the outpatient service following a suicide attempt were admitted to the general pediatric/adolescent service. In addition to the care provided by the medical and nursing staffs, these patients received evaluation and crisis intervention by the staff clinical psychologist with consultations by a child psychiatrist as indicated. Suicidal patients were not singled out from the regular inpatient population and were expected to participate in all ward activities.

To evaluate the lethality of the suicidal attempt, the definition of lethality (i.e. the probability that the patient will attempt suicide in the immediate future) as described by Scheidman was applied.[5]

RESULTS

From July, 1979, to July 1, 1980, 1,830 children were admitted to the children/adolescent service of Jersey City Medical Center which admits children 3.0

*From the Department of Pediatrics, Jersey City Medical Center where Dr. Pierog is Director of Pediatrics and Dr. Hill is a Clinical Psychologist. Correspondence may be addressed to Dr. Pierog, Jersey City Medical Center, 50 Baldwin Avenue, Jersey City, NJ 07304.

TABLE 1

Suicidal Adolescents

Patient	Sex	Age	Previous Attempt(s)	Loss of Parent*	Use of Ethanol	Lives With/In:
1	M	12.5	3	F	No	Shelter
2	F	14.1	0	F	No	M
3	F	15.11	1	F	F	M and Step F
4	F	15.3	0	No	F and Patient	Shelter
5	F	15.9	Many	Both	Foster Parents	Shelter
6	M	15.5	1	Both	Patient	Shelter
7	M	15.0	0	F	—	M
8	F	15.2	0	No	F	Both
9	F	14.10	3	F	Step F and Patient	M and Step F
10	F	15.6	0	F	Patient	M
11	F	14.11	0	F	No	Shelter
12	F	15.2	0	F	No	M
13	M	16.5	2	F	Patient	Shelter
14	F	13.10	1	F	Patient	M
15	F	15.9	3	No	F and Patient	Both
16	F	14.1	0	F	F	M
17	F	12.4	0	F	M	Foster Parents
18	F	14.4	0	F	No	M
19	F	14.7	0	F	No	M
20	F	14.1	0	F	No	M
21	F	7.8	0	F	No	M
22	F	14.8	0	F	M	M
23	F	15.5	2	F	M	Foster Parent
24	M	15.2	0	Both	Patient	Foster Parent
25	F	15	0	No	No	Both
26	F	15	1	No	F	Both
27	F	13.10	0	No	Both	Both
28	F	11.9	0	Both	No	Foster Parent

*F = Father; M = Mother

to 15.11 years of age. Jersey City Medical Center is a 625-bed, urban hospital which is the residency teaching center for Hudson County. Satellite hospitals in the county transfer problem patients to the Medical Center for care.

Twenty-eight adolescents/preadolescents were admitted for attempted suicide in that year; 1 adolescent was 16.5 years of age. Twenty-three patients were female and 5 patients were male, giving a ratio of 4.6 to 1, female to male. Of the 23 female patients, 11 or 48 percent were Hispanic surnamed. The data on the 28 patients are presented in Table 1.

The ethnic distribution of the children consisted of 11 black (39 percent), 4 white (14 percent), and 12 Hispanic surnamed (46 percent) adolescents. The demographic data from the 1970 census of Hudson County (Jersey City is the major city and county seat) shows a distribution of population to be 34.5 percent black, 60 percent white, 42 percent Hispanic, and 1.3 percent other. Ten of 28 patients (7 female and 3 male)

had a history of previous suicide attempts; 1 had too many to recall and the rest had 1 to 3 attempts.

Of 28 patients, 22 had a loss of one or both parents (by death, divorce, or separation), 6 were living in shelters, and 4 were in foster care. The parent, surrogate parent, the patient, or some combination of these had an alcohol problem in 17 cases; 7 of the children had an alcohol problem. Of the female adolescents, 4 or 17 percent were pregnant at the time of their attempt.

The most frequent precipitating event was a conflict with a parent or parent surrogate (Table 2). These conflicts most often involved issues of parental or authority control. The most frequent method used in the attempt was ingestion of toxic or potentially toxic substances (22 or 79 percent); drugs used included aspirin, phenobarbital, anticonvulsants, alcohol, and cleaning products. Seven cases of the substance ingestion were considered moderate to high lethality, 3 patients inflicted bodily injury and 3 threatened to jump out the window from 4 to 8 stories (Table 3).

The initial diagnoses of all 28 patients are listed in Table 4; the most common was adjustment reaction of adolescents. Twenty-seven or 96 percent were depressed at the time they were interviewed by the clinical psychologist and all 28 were noted to be angry. The average stay on the pediatric/adolescent ward was less than two weeks and all but 1 of the patients were discharged to the community with appropriate referrals to after-care facilities. One child was transferred to the adult inpatient psychiatric unit for longer treatment.

All patients had initial constant nursing observation for at least four to eight hours. All were treated with minimal disturbance to the pediatric ward routine and none of the patients attempted to hurt themselves or others while on the ward.

TABLE 2

Events Precipitating the Adolescent Suicide Attempt

Reason	No.
Parental conflict	15
Parental/caretaker conflict	18
Romantic conflict	6
Personal loss	1
Legal problems	2
Peer problems	1
Not noted	1

TABLE 3

Method of Suicide Attempt and Lethality

	No.	Lethality Low	Moderate	High
Pills	18	12	4	2
Threatened to jump out of window	2	2		
Slash wrist/stab self	3	2	1	
Alcohol	1	1		
Alcohol and pills	2	2		
Other chemical ingestion	1		1	
Combination (window and slash)	1		1	
Total	28			

DISCUSSION

Verifying Marks's findings, we found that suicidal adolescent patients adjusted well in a general pediatric ward, they were effectively controlled, and they were able to be discharged for outpatient followup.[4] None of our patients was deemed psychotic which also was consistent with Marks's findings (10 percent of her patients were considered psychotic). Suicidal activity appears to be a way of attempting to deal with stress rather than a reflection of severe mental illness. The pediatric/adolescent ward, therefore, is an appropriate facility to treat the patient, relieving the patient and family of the stigma often associated with psychiatric hospitalization. In addition, it was noted that the presence of the suicidal adolescents in the general pediatric ward was not disruptive to the ongoing functioning of that ward. It seldom was necessary to supply special nursing services for the suicidal adolescents beyond the observation period of less than four to eight hours. Though each of the patients was referred for outpatient psychiatric care on discharge it was not the attempt of this study to follow up on the compliance of the patient. The preponderance of female patients (82 percent) is consistent with previous studies.[3,6] In our study there seemed to be a disproportionate number of Hispanic adolescents admitted for suicidal behavior (46 percent) with a preponderance of Hispanic females. Again, this is consistent with Marks's finding in that there seemed to be an ethnosexual mode of expression manifest in their suicidal adolescents. Our findings are striking considering the Hispanic population of Jersey City numbers only 4.2 percent of the 1970 census. Taking into account the growth of the Hispanic population in the last decade, the Hispanic population seems to be considerably rep-

TABLE 4

Initial Psychiatric Diagnosis upon Admission: Patterns of Behavior Dysfunction

Diagnosis	No.
Child abuse (targets of abuse by adults)	3
Adjustment reaction of adolescence	8
Runaway reaction	3
Unsocialized aggressive reaction	5
Inadequate personality (borderline)	2
Depressive neurosis	4
Seizure disorder	1
Hysterical neurosis	1
Group delinquent reaction	1
Total	28

resented. A noteworthy number (36 percent in our study) of our suicidal adolescents had admitted to or were known to have made previous suicide attempts; in most of the suicide attempts, drugs were used.

Sexual stress factors appear to be a common denominator in predisposing adolescents to suicide attempts. Actual pregnancy or fear of pregnancy (17 percent in our study) was one such factor; separation from parental figure(s) is another. Several studies show an absence of parental figures, notably the fathers in 51 to 72 percent of these youths. Hospitalization of these youngsters, therefore, would meet the need of the teenager for nurturance and structure. Parental use of alcohol also appears to be a common problem; seven children were involved with alcohol as well.

CONCLUSION

It is clear that the youngsters who attempted suicide are ordinary youngsters responding in an angry, impulsive fashion to the environmental stresses which result from parents, peers, drugs, and authorities. A sensitive family physician or pediatrician should be able to help the child solve problems by more acceptable means and prevent the morbidity associated with suicidal attempts.[1,3,7]

REFERENCES

1. Committee on Adolescence, American Academy of Pediatrics: Teenage suicide. *Pediatrics* 66: 144-146, 1980.
2. Ravenhorst JM: Followup of young women who attempt suicide. *Dis Nerv Syst* 33:792, 1972.
3. McAnarney ER: Suicidal behavior of children and youth. *Pediatr Clin of NA* 22:595-604, 1975.
4. Marks A: Negligible risks in the management of the suicidal teenager on a nonpsychiatric adolescent unit. *J Pediatr* 95:305-308, 1979.
5. Scheidman ES: *Essays in Self-Destruction.* New York, NY, Science House, 1967.
6. Rohn RD, Sarles RM, Kenny TJ, Reynolds BJ, Heald FP: Adolescents who attempt suicide. *J Pediatr* 90:636-638, 1977.
7. Cunningham DG: Are pediatricians qualified to judge suicide gestures? *Pediatrics* 67:750, 1981.

Motrin®
ibuprofen, Upjohn
600 mg Tablets



More convenient for your patients.

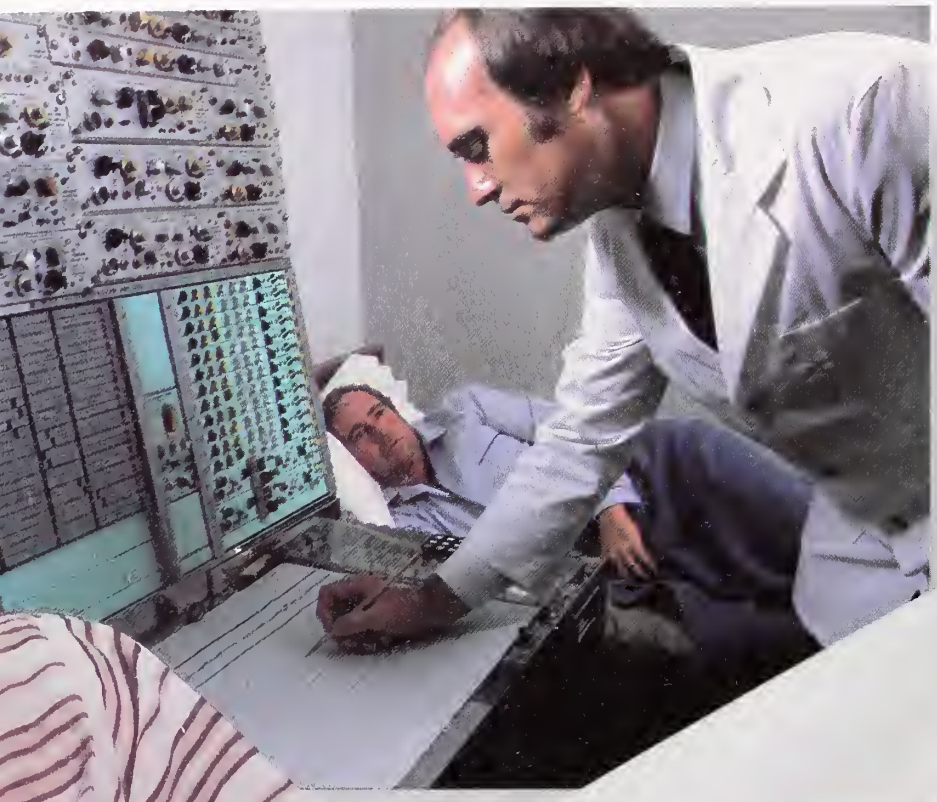
Upjohn

'84 The Upjohn Company

The Upjohn Company • Kalamazoo, Michigan 49001 USA

J-4044 January 1984

ONLY DALMANE®
flurazepam HCl/Roche
IMPROVES SLEEP...



WITH COMPLETE SLEEP LABORATORY PROOF[1-5]...

Copyright© 1984 by Roche Products Inc. All rights reserved

N ALL THESE WAYS

- Rapid sleep onset[1-6]
- Effective for middle-of-the-night and early-morning awakenings[2,5]
- Undiminished efficacy for at least 28 nights[2-4]
- Patients usually awake rested and refreshed[7-9]
- Avoids rebound insomnia after discontinuation of therapy[3,5,10-12]

Caution patients about driving, operating hazardous machinery or drinking alcohol during therapy. Limit dose to 15 mg in elderly or debilitated patients. Contraindicated during pregnancy.



AND THE PREDICTABILITY THAT COMES WITH EXPERIENCE

FOR EFFECTIVE RELIEF OF INSOMNIA

DALMANE® (IV)

flurazepam HCl/Roche

STANDS APART



15-MG/30-MG CAPSULES

See next page for references and summary of product information.

References: 1. Kales J *et al: Clin Pharmacol Ther* 12:691-697, Jul-Aug 1971. 2. Kales A *et al: Clin Pharmacol Ther* 18:356-363, Sep 1975. 3. Kales A *et al: Clin Pharmacol Ther* 19: 576-583, May 1976. 4. Kales A *et al: Clin Pharmacol Ther* 32:781-788, Dec 1982. 5. Frost JD Jr, Peluccht MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 6. Kales A, Kales JD: *J Clin Pharmacol* 3:140-150, Apr 1983. 7. Monti JM. *Methods Find Exp Clin Pharmacol* 3:303-326, May 1981. 8. Greenblatt DJ *et al: Sleep* 5 (Suppl 1):S18-S27, 1982. 9. Kales A *et al: Pharmacology* 26:121-137, 1983. 10. Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther* 21:355-361, Mar 1977. 11. Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. 12. Amrein R *et al: Drugs Exp Clin Res* 9(1):85-99, 1983.

Dalmane® Ⓥ
flurazepam HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided, with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

If your professional liability insurance company ran out of money, you could find yourself very much . . .

. . . alone.

We're 6,900 New Jersey physicians insuring *ourselves* through our own non-profit company. If you haven't joined us, you could be more at risk than you know. You owe it to yourself — and those that depend on you — to call us for more information.

800-257-6288

Do it now. Everything is at stake.

A professional service message from the
Medical Inter-Insurance Exchange of N.J.
Two Princess Road, Lawrenceville, NJ 08648
(609) 896-2404
*"The **Doctors'** Company"*

A Method of Abdominal Wound Closure

Ian D. Samson, M.D., Jesse Schulman, M.D., Jack C. Sabo, M.D., William M. Schulman, M.D., Lawrence W. Silvers, M.D., Lakewood*

A technique for the secure closure of abdominal incisions is described utilizing mass approximation of tissues by a continuous, looped, nonabsorbable nylon suture which is shown to have a low incidence of undesirable sequelae. Ease and speed of insertion, low cost, and low complication rate make this an attractive method of abdominal wound closure.

A number of techniques for abdominal wound closure have been proposed. The rationale for the use of a method is based on surgical dogma and traditional teaching rather than on scientific fact or on an analysis of personal experience. The preferred method of abdominal wound closure should be: 1) universally applicable, simple, and inexpensive; and 2) accompanied by a low incidence of untoward complications, such as wound disruption, late incisional hernia formation, discharging sinus with the extrusion of suture material, and a chronically painful scar.

Since 1977, we have been using a continuous monofilament, nonabsorbable suture for abdominal wall closure. From 1980, stimulated by the excellent results reported by Jenkins, we have used a looped nylon suture for this purpose.[1]

This study is a prospective analysis of our experience with the latter method, which we believe approximates the ideal.

PATIENTS AND METHODS

Since February 1980, all patients undergoing celiotomy had the abdominal incision closed with a looped nylon suture and were included in the prospective study. Since the study was terminated in July 1982, an additional 167 patients had their wound closed using the identical technique but were analyzed only for wound disruption and early hernia formation. No escape clause was provided. The study, therefore, includes patients with fecal contamination of the peritoneum, as well as patients with frank intra-adominal sepsis. Midline incisions were approximated as a mass closure incorporating both fascia and peritoneum in a running suture. The suture was constructed of 183 cm of #0 nylon swagged onto an XLH needle to provide a usable suture length of 91.5 cm. The suture was prepared by Ethicon for this purpose (Figure 1). In most cases, a single length of suture was sufficient to accomplish closure. However, for wounds of extraordinary length, i.e. for the resection of an abdominal aortic aneurysm, it was necessary to use two or possibly three lengths of suture to obtain closure without undue tension. An attempt was made to obtain a suture:wound length ratio of a least 3:1 and preferably 4:1 to achieve a firm but relaxed wound closure. The initial bite was taken just beyond the apex of the wound and the needle was passed through the loop to anchor one end. Successive bites of fascia and peritoneum were taken at least 1.5 cm from the wound edge and 1 to 1.5 cm apart, with only enough tension to approximate the wound edges. When the peritoneum could not be included in the closure for technical reasons, no special effort was made to do so, and the fascia alone was approximated. When fascia and

*From Paul Kimball Medical Center and Community Memorial Hospital, Lakewood. Correspondence may be addressed to Dr. Samson, 5 Prospect Street, Lakewood, NJ 08701.



Figure 1—Looped nylon suture showing apex of loop **(A)** and both ends swagged on to XLH needle **(B)** (Ethicon).

peritoneum were taken together, the peritoneum was prevented from protruding between the fascial edges. A simple technique for burying the knot was devised, thereby preventing extrusion of the cut edges of the suture through the skin or into the abdominal cavity. When near completion of the closure, the looped suture was drawn through the fascia from its superficial to deep aspects and then one strand of nylon was cut free from the needle. The second strand then was brought out through the opposite side from the deep to the superficial aspects of the fascia and finally returned from superficial to deep to the fascia. The suture then was snugged up and tied so that the knot was placed deep to the fascia. The ends of the suture were left long and were brought through the last three previously placed loops with a modified aneurysm needle and then cut flush (Figures 2 to 5).

Kocher and transverse incisions were closed in one or two layers. When a two-layer closure was selected, the deep layer consisted of a continuous 0 Vicryl while the superficial layers were approximated using the looped nylon suture in the same manner that was used for a vertical incision. Single-layer closure for transverse and Kocher incisions was carried out using identical maneuvers to those used for vertical incisions.

When appropriate, an antibiotic-containing solution was used to irrigate the peritoneal cavity. On occasion, when gross contamination was evident, a povidone-iodine solution was instilled into the subcutaneous tissue after careful wound irrigation. In the presence

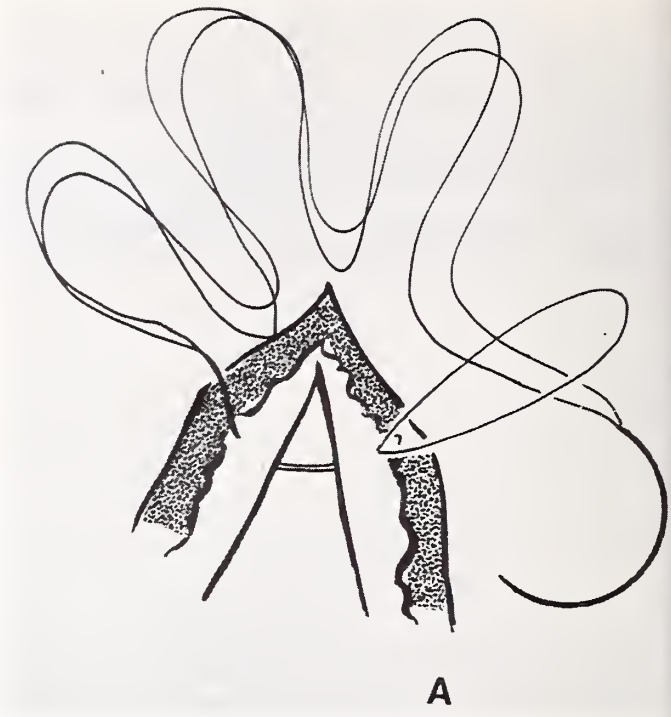


Figure 2—Closure technique.



Figure 3—Closure technique.

of severe infection or contamination, the skin was not closed. No other form of reinforcing sutures, such as a retention suture, was used. When drains were required they always were placed away from the closure and brought out through separate incisions. In one instance, a mucous fistula was brought out through the lower end of the wound. Active colostomies were brought out through a separate incision as far removed as possible from the wound closure. Primary maturing of the colostomy was employed frequently. Each procedure carefully was documented and data were recorded for age, sex, and complicating factors. (e.g. cardiac failure, jaundice, respiratory disease,

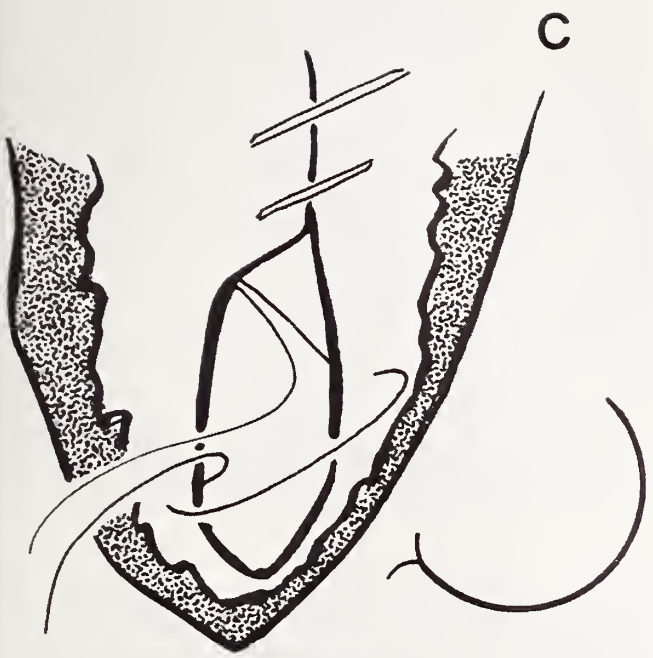


Figure 4—Closure technique.



Figure 5—Closure technique.

uremia, hypoalbuminemia, steriods, incisions, reoperations). Surgical details included the nature of the procedure (elective or emergent), type of procedure, and nature of the incision (midline, transverse, paramedian, or Kocher). The degree of contamination was recorded as clean, potentially contaminated, or frankly contaminated. The presence or absence of ascites was noted. Further details concerning the precise method of closure, the length of the wound, depth of the fat, and closure time also were recorded. All wounds were evaluated at the time of discharge and at six months. Complications such as evisceration, late hernia formation, and prolonged wound sepsis were documented.

FINDINGS

In this study, 234 patients were entered: 140 females and 94 males. Their ages ranged from 16 years to 95 years. The vast majority of patients (162) were in the 60 to 69 age group and the 70 to 79 age group. Seventy percent of the procedures were elective while 30 percent were emergent operations. Thirty-nine patients were classified as thin, with abdominal wall fat measuring less than 1.5 cm in depth. One hundred twenty-one were classified as of average build, with abdominal wall fat of between 1.5 and 3 cm in depth, while 52 were considered obese, with abdominal wall fat of greater than 3 cm in depth. Of that last group, 13 were considered massively obese, and had abdominal wall fat measuring more than 6 cm. One hundred twenty-one closures were midline, and 76 were Kocher incisions. There were 26 transverse incisions and 3 paramedian incisions. Eighty-eight operations were considered clean, 109 were potentially contaminated, and 33 were frankly contaminated. Ascites was present in 6 cases. Twenty-nine of the Kocher and transverse incisions were closed with a single-suture technique while the remainder were closed using a superficial and a deep layer. There were two wound dehiscences, both associated with vertical incisions. No eviscerations occurred. All wounds were healed soundly at the time of discharge, with the exception of some that were allowed to heal by secondary intention. No hernias were encountered at the time of discharge. We followed 172 patients for six months. At this time there were 2 incisional hernias and 2 patients had wound sepsis. There were no cases of extruding suture material, and no patient had significant complaints concerning his or her wound. An additional 167 wounds were closed in the same manner and were evaluated for healing at the time of discharge; all were found to be healed soundly.

Very little time was expended in closing the fascial layers. Vertical incisions measuring less than 24 cm in length were approximated, in an average of 7.3

TABLE 1
Predisposing Factors

Obesity	51
Frank sepsis	33
Previous operative scars, hernia, and early reoperation	23
Hypoalbuminemia	17
Pulmonary disease	17
Jaundice	11
Uremia	5
Cardiac failure	5
Steroids	3
Others	3
Irradiation	1

minutes, while those measuring in excess of 31 cm took 11 minutes to close. Transverse and Kocher incisions averaged 18 cm in length and took 7.6 minutes to close in two layers and 5.8 minutes to close when a single layer was used. The expeditious closure was appreciated at the end of long, tedious procedures!

There were 186 classical complicating factors predisposing to wound failure present. The most commonly encountered problems (Table 1) were obesity (51), frank sepsis (33), previous operative scars, hernia, and early reoperation (23), hypoalbuminemia (17), chronic obstructive pulmonary disease (17), and jaundice (11). It is felt that this pattern of complications probably does not vary significantly from that commonly seen in everyday surgical practice.

DISCUSSION

The fact that the debate concerning the virtues and pitfalls of suture materials and techniques is neverending serves to notify us that the ideal form of abdominal incision closure has not been determined or, if it has, we have failed to recognize it. For most, habit, prejudice, and surgical dogma have come to be as important as scientific analysis in the selection of a closure technique.

In any analysis of wound closure techniques, consideration is given to both the material used and the method of its insertion. With regard to suture material, Table 2 shows the acceptable classification.

There are two primary methods of suture placement. The first involves separate approximation of the individual layers of the abdominal wall—layered closure. The second method is that of approximation of all layers within a single suture—mass closure. In almost all instances the skin is excluded in mass closure. However, in cases of wound disruption, mass closure including all layers of the abdominal wall is commonly utilized.

Layered closure almost universally is selected for the closure of oblique and transverse abdominal incisions, and has its proponents for the closure of vertical incisions as well. The technique of mass closure usually is employed in vertical wounds, and in the repair of wound dehiscense, irrespective of the position of the primary incision.

The mass closure technique has been shown experimentally to be superior in the early phase of wound healing, where extrinsic strength is a major consideration.[2] This finding has been borne out by clinical experience.[3]

Further consideration occasionally is given to providing additional support to the closure by adding some form of buttress or retention layer.[4] This secondary supporting layer rightly should be considered as an extension of mass closure. It has been recommended even when formal mass closure has been used.[5] However, more frequently it is used to support a layered closure when an absorbable suture has been used to approximate the fascia.[3] Whether or not retention sutures add anything of substance to a mass closure has not been demonstrated adequately. In a prospective series comparing closures with and without the addition of retention sutures, Hubbard and Rever found a significantly higher rate of dehiscense when retentions were used.[6]

TABLE 2

Suture Material

1. Nonabsorbable

- A. Natural
  - 1. Cotton
  - 2. Silk
- B. Synthetic
  - 1. Polyamide (nylon)*
  - 2. Polyester*
  - 3. Polypropylene (prolene)
  - 4. Metallic (thread)*/(staple)

2. Absorbable

- A. Natural
  - 1. Catgut
  - 2. Collagen
- B. Synthetic
  - 1. Polyglycolic acid
  - 2. Polyglactin*

*Monofilament or braided

As the advantages of this additional layer are doubtful at best, it is proposed that the discomfort and unsightly scarring produced by retention sutures, as well as the increase in operating time, do not warrant its usage.

Other factors that apply to the closure concern the physieal changes exerted by differing methods of suture placement and by the inherent characteristics of the material per se. In the first instance, knot slippage is a function of the suture material. A spectrum exists that extends from the great security that is found in a knot placed in wire to a propensity for loosening and slippage that is found with moistened plain catgut. In general, one can conclude that the fewer knots that are required to be placed, the less likely the closure is to come apart. A continuous suture technique therefore would have a theoretical advantage over an interrupted one, as there are less knots to come loose. Other than knot security, the integrity of the suture material is of considerable significance. Ideally the material should be nonreactive, retain its tensile strength throughout the period of maturation of the suture line, and be totally resorbed. Such a material is not available. These characteristics are approached by the modern absorbables (e.g. polyglactin), which are relatively nonreactive but undergo progressive dissolution from the time of insertion, and on the other hand, by the monofilament nonabsorbables (e.g. nylon), which are virtually inert, and maintain their tensile strength but are retained in the body indefinitely.

Secondly, it would seem that precise fascial approximation is important. In all midline incisions, it is appropriate to oppose in an accurate fashion the raw fascial edges, rather than to incorporate fat or peritoneum between these edges. Where the mesothelium becomes interposed between fascia, a weaker scar is produced, and it has been demonstrated that a mesothelial to mesothelial scar is less secure than one between raw fascial edges.[7]

A further consideration is the provision for stretching of the wound in the postoperative phase due to edema and abdominal distension. Jenkins es-

tablished an experimental model to calculate the reverse of suture length necessary to allow for this lengthening and to ensure a minimal resulting rise in tension between the sutures and the tissues.[1] The findings were extrapolated and used in a clinical series with a dehiscense rate of 0.5 percent. He concluded that wound disruption due to cutting out of sutures can be prevented by the use of nonabsorbable continuous sutures placed at 1 cm intervals and a suture: wound length ratio of 4:1 or more.

A review of the recent literature reveals a number of studies evaluating a fairly wide spectrum of techniques and suture materials.[8-13] The infection rate varies from 4.1 to 24.8 percent, sinus rate from 0 to 14 percent, dehiscence rate from 0 to 10.2 percent, and the late hernia rate from 9 to 11.5 percent. The best figures were obtained using a mass closure with a continuous nylon suture[1] or continuous polyglycolic acid and polyglactin.[9] An outline of the relevant findings is illustrated in Table 3.

The results of the present series compare favorably with those reported. Our incidence of wound dehiscence was 0.7 percent in a totally unselected group of patients, which included an unusually large elderly population. There were no cases of late wound infections and no wound sinuses. The late hernia rate was less than 1 percent.

Irrespective of the technique used for wound closure, the final objective should be the same: to produce a soundly healed, comfortable wound with no predisposition to early or late herniation, and a wound dehiscence rate that approaches zero. Secondary considerations, such as the cost of material and speed of closure, should be borne in mind but obviously are not major determinants in the final outcome. Of prime importance, however, is the need for the technique in question to be reproducible and attainable by both novice and expert alike.

CONCLUSIONS

A number of tenets have surfaced from experimental data and from the reported and present series. The first is that mass closure is preferable to layered closure. The second is that the interrupted suture technique is no better than the continuous one. This being the case, the continuous suture technique is preferable because it is more expeditious. Finally, buttressing or retention sutures are not required.

The closure method outlined in our study has an acceptably low dehiscence and hernia rate, and is not

TABLE 3

*Review of the Literature**

Reference	Suture	L	M	C	I	R	IN	S/IN	D	H	T	Comments
Goligher et al.[3]	Catgut	X		X		X	9.3	1.9	10.2	3.7	13.9	Reinforced, paramedian ant. layer interrupt
	Catgut	X		X		X	15.4	10.6	0.96	3.8	4.8	
	Wire		X		X		10.2	4.6	0.93	0	0.93	Jones
Irvin et al.[11]	Polyglycolic	X			X			9.6	5.8	3.8	9.6	
	Polyglactin	X			X			7.7	—	5.8	5.8	
	Polypropyl	X		X				14.0	3.5	5.3	8.8	
Jenkins[1]	Looped Nylon		X	X			0.07	0.0007				Vertical only
Leaper et al.[8]	Nylon	X		X			20.3		0.86	5.2	6	Chromic-peritoneum
	Wire		X		X		21.7		0.83	8	8.8	Jones
	Polyglyctin		X		X		24.8		0	5.1	5.1	Jones
Sloop[9]	Polyglycolic Polyglactin		X	X			0	0	0	0	0	Transverse 2 layers
Bucknall and Ellis[10]	Nylon		X	X			21.4	9.4	0.94	3.8	4.8	Vertical only 40 percent
	Polyglactin		X	X				11.5	0.96	11.5	12.5	Infections developed sinuses
Corman et al.[12]	Nylon		X		X		4.1	12.2	0	8.9	8.9	Bowel surgery
	Polypropyl		X		X		9.4	5.7	1.9	4.4	6.3	
	Polyglactin		X		X		10.2	0	0	0	0	
Samson et al.	Nylon		X		X				0.5	1		
Richards et al.[13]	Polypropyl	X	X	X					2	2		
	Polyglycolic	X	X		X				0.9	0.5		

(L) Layered, (M) Mass, (C) Continuous, (I) Interrupted, (R) Retention, (IN) Infection, (S/IN) Sinus and/or Infection, (D) Dehiscence, (H) Hernia, (T) Total Complications.

*Complications expressed in percentages.

accompanied by significant morbidity, such as painful or infected wounds with sinuses. Furthermore, it is exceptionally inexpensive in terms of materials and closure time is rapid. Our findings support the excellent results reported by Jenkins.[1] We are encouraged by this analysis to persist with this closure method, and recommend it to others for their consideration.

REFERENCES

1. Jenkins TPN: The burst abdominal wound: A mechanical approach. *Br J Surg* 63:873-876, 1976.
2. Dudley HAF: Layered and mass closure of the abdominal wall: A theoretical and experimental analysis. *Br J Surg* 57:664-667, 1970.
3. Goligher JC, Irvin TT, Johnston D, DeDombal FT, Hill GL, Horrocks JC: A controlled clinical trial of three methods of closure of laparotomy wounds. *Br J Surg* 62:823-829, 1975.
4. Old WL Jr, Stokes T: Preventing disruption of abdominal wounds. *South Med J* 72:545-550, 1979.
5. Ponka JF: *Hernias of the Abdominal Wall.* Philadelphia, PA, W.B. Saunders Co., 1980, p. 356.
6. Hubbard TB Jr, Rever WB Jr: Retention sutures in the closure of abdominal incisions. *Am J Surg* 124:378-380, 1972.
7. Myers B, Rightor M, Donovan W: An experimental model in the rat to evaluate technical factors. *Arch Surg* 116:463-465, 1981.
8. Leaper DJ, Pollack AV, Evans M: Abdominal wound closure: A trial of nylon polyglycolic acid and steel sutures. *Br J Surg* 64:603-606, 1977.
9. Sloop RD: Running synthetic absorbable suture in abdominal wound closure. *Am J Surg* 141: 572-573, 1981.
10. Bucknall TE, Ellis H: Abdominal wound closure—a comparison of monofilament nylon and polyglycolic acid. *Surgery* 89:672-677, 1981.
11. Irvin TT, Koffman CG, Duthie HL: Layer closure of laparotomy wounds with absorable and nonabsorbable suture materials. *Br J Surg* 63:793-796, 1976.
12. Corman ML, Veidenheimer MC, Coller JA: Controlled clinical trial of three suture materials for abdominal wall closure after bowel operations. *Am J Surg* 141:510-513, 1981.
13. Richards PC, Balch CM, Aldrete JS: Abdominal wound closure—a randomized prospective study of 571 patients comparing continuous *v* interrupted suture techniques. *Ann Surg* 197:238-243, 1983.

Case Report: Aneurysm of the Descending Thoracic Aorta

Shashi K. Agarwal, M.D., Jacob I. Haft, M.D., Michael Bachik, M.D., Newark*

The detection of a descending thoracic aortic aneurysm by M-mode echocardiography is an unreported phenomenon. Confirmation by cross-sectional echocardiography illustrates the value of noninvasive techniques in the study of the descending thoracic aorta.

Cross-sectional echocardiography provides a noninvasive visualization of the entire aortic root[1,2] and has allowed recognition of disease of this great vessel.[3,5] Using contrast echocardiography, Mintz et al. have shown that the descending thoracic aorta easily can be seen in the parasternal long and short axis views.[6] We recently recognized a large aneurysm of the descending thoracic aorta by cross-sectional echocardiography. Unusual M-mode echocardiographic findings also were observed.

CASE REPORT

The patient was a 76-year-old white female who was admitted to Saint Michael's Medical Center, Newark, for evaluation of shortness of breath. Associated symptoms included cough with yellowish expectoration and fever with chills. Since the chest roentgenogram revealed no parenchymal lung infiltrates (mediastinal widening was noted), a diagnosis of upper respiratory tract infection was made (Figure 1). The patient was known to have hypertension for 20 years. Two months prior to this admission, she was hospitalized elsewhere with interscapular pain and diaphoresis. A widened mediastinum was noticed on the chest roentgenogram. Angiography was performed and a thoracic aortic aneurysm was diagnosed (Figure 2).

The recent admission offered a unique opportunity to evaluate the use of two-dimensional echocardiography in visualizing aneurysms of the descending thoracic aorta. In the parasternal long axis view (Figure 3), a large pulsatile echo-free space with a diameter of 45 mm was noted. On gradually sliding the transducer to a lower parasternal position, the descending aorta could be visualized lengthwise, clearly demonstrating the aneurysmal dilatation (Figure 4). A double posterior aortic wall also could be seen in this view, confirming the angiographic findings of an associated type III dissection. In the apical four-chamber view, the aneurysm could be visualized just behind the left atrium by gently rocking the transducer medial to lateral. An M-mode echocardiogram revealed an echo-free space behind the left atrium that expanded just behind the atrio-ventricular groove (on sweeping), also reflecting the descending aorta and its aneurysm (Figure 5).

DISCUSSION

Thoracic aortic aneurysms usually exhibit progressive enlargement and pose the danger of a catastrophic complication such as rupture.[7] Further, they may cause compression of adjacent structures resulting in considerable morbidity. Since surgical in-

*From Saint Michael's Medical Center, Newark. Correspondence may be addressed to Dr. Agarwal, Department of Cardiology, Saint Michael's Medical Center, 306 High Street, Newark, NJ 07102.

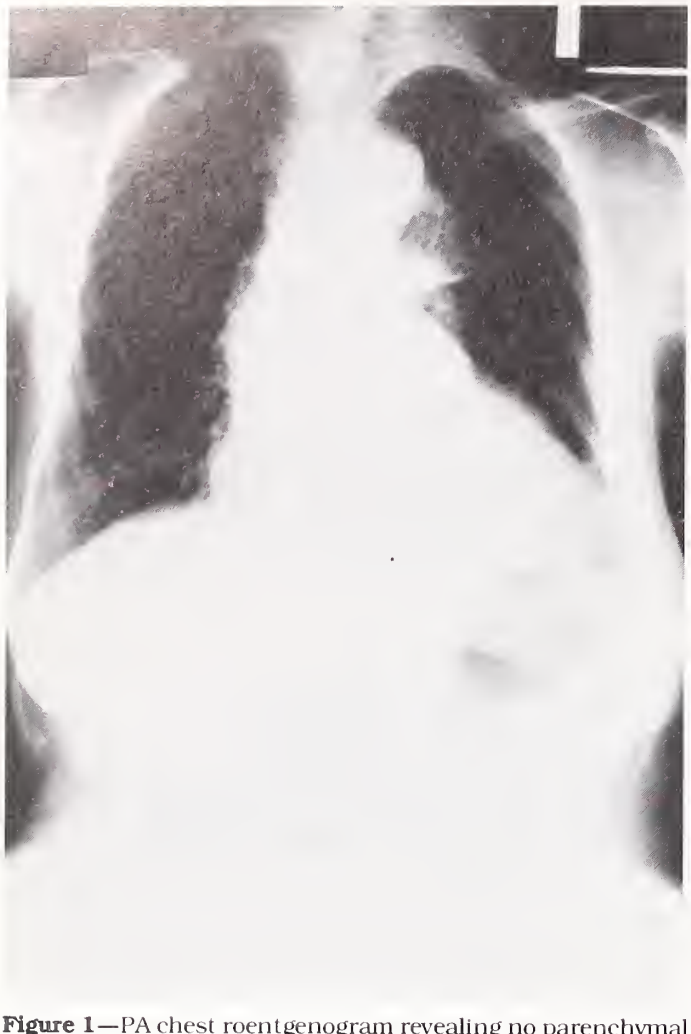


Figure 1—PA chest roentgenogram revealing no parenchymal lung infiltrates (mediastinal widening was noted); diagnosis of upper respiratory tract infection was made.



Figure 2—Retrograde aortic angiography. The arrow shows the aneurysmal dilatation.

tervention is useful, early diagnosis is of major importance in their management.[8] Although a chest roentgenogram may be suggestive, reliable diagnosis usually mandates aortography. Two-dimensional echocardiography, by providing spatial orientation, may afford a simple noninvasive alternative.

Demonstration of the descending thoracic aorta by cross-sectional echocardiography has helped in the diagnosis of aneurysm,[6] patent ductus arteriosus[9] and differentiation of pleural from pericardial effusion.[10] Usually, it is seen best in the long axis view as a pulsatile circular echo-free space posteriosuperior to the AV groove; it measures 10 ± 1.4 mm/m² in diameter at this level.[6] In short axis view, it can be seen directly behind the left ventricle (LV) posterior wall or just posterior to the bifurcation of the pulmonic artery. This case illustrates that in some patients a low parasternal long axis view may visualize the whole descending thoracic aorta lengthwise and may be superior for recognizing abnormalities of this segment (Figure 4). The large aortic aneurysm in our patient also was seen in the apical four-chamber view just behind and lateral to the left atrium.

The demonstration of the aortic aneurysm on M-mode echocardiography was unusual in our patient. An echo-free space behind the left atrium sometimes is recorded and has been attributed to the common pulmonary vein,[11] coronary sinus in total anomalous pulmonary venous drainage,[12] pleural effusion,[13] or

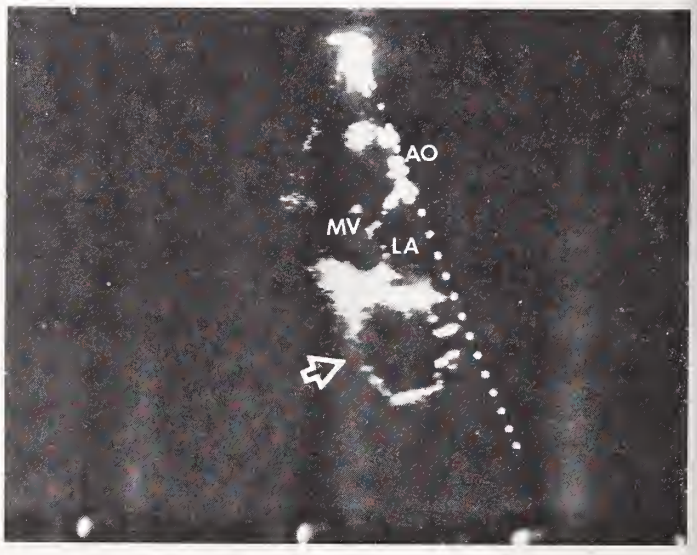


Figure 3—A cross-sectional echocardiogram; parasternal long axis view. The aortic aneurysm (arrow) is seen just behind the AV groove. AO=aortic root; MV=mitral valve; LA=left atrium.

pericardial effusion.[14] Contrast echocardiography has revealed that the normal descending aorta often will appear as an abnormal echo behind the left atrium.[15] The demonstration of an increase in size of the echo-free space on sweeping from the left atrium (LA) to the mitral value level on the M-mode echocardiogram in our patient probably reflects the descending thoracic

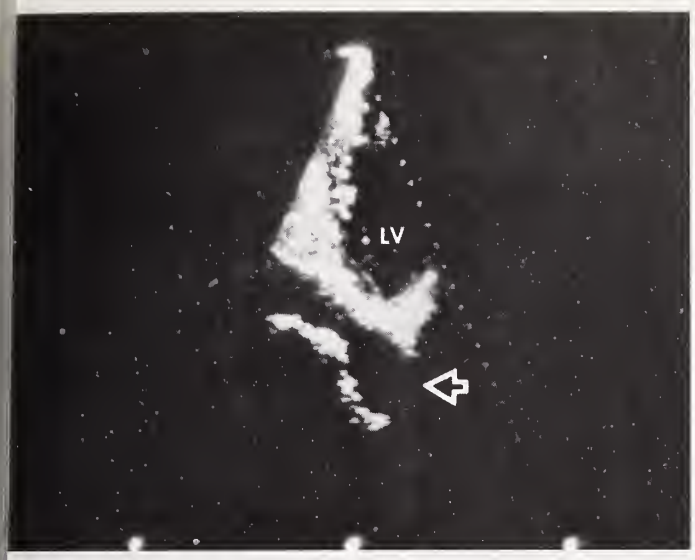


Figure 4—A cross-sectional echocardiogram; low parasternal short axis view. The descending thoracic aorta and its aneurysm (arrow) is visualized.

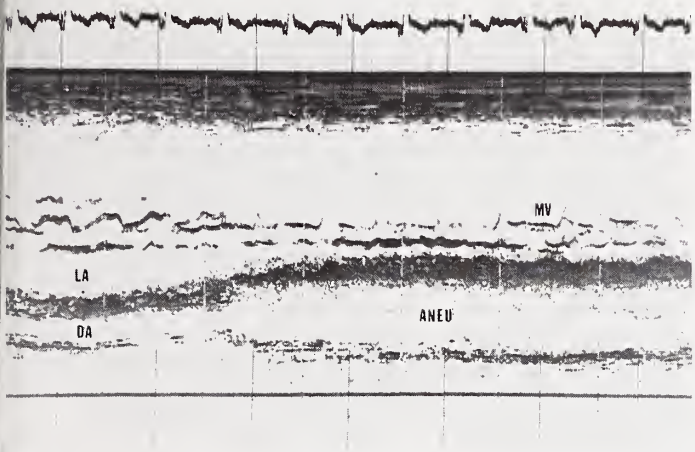


Figure 5—M-mode echocardiogram; aorta to mitral valve sweep. Note the increase in size of the echo-free space behind the pericardium. LA=left atrium; DA=descending aorta; MV=mitral value; ANEU=aneurysm.

aorta and its aneurysmal dilatation. Close observation reveals systolic expansion.

CONCLUSION

Our case report illustrates the potential use of cross-sectional echocardiography in the assessment of patients suspected of having thoracic aortic aneurysm and, in selected cases, reliably may be substituted for conventional retrograde angiography. Unusual M-mode echocardiographic findings also are described.

REFERENCES

1. Seward JB, Tajik AJ: Two-dimensional echocardiography. *Med Clin North Am* 64:177-203, 1980.

2. Kotler MN, Mintz GS, Segal BS, et al.: Clinical use of two-dimensional echocardiography. *Am J Cardiol* 45:1061-1082, 1980.

3. DeMaria AN, Bommer W, Newman A, et al.: Identification and localization of aneurysms of the ascending aorta. *Circulation* 59:755-761, 1979.

4. Matsumoto M, Matsuo H, O'Hara T, et al.: A two-dimensional echocardiographic approach to dissecting aneurysms of the aorta to prevent false positive diagnosis. *Radiology* 127:491-499, 1978.

5. Weyman AE, Caldwell RL, Hurwitz RA, et al.: Cross-sectional echocardiographic detection of aortic obstruction. 2. Coarctation of the aorta. *Circulation* 57:498-502, 1978.

6. Mintz GS, Kotler MN, Segal BL, et al.: Two-dimensional echocardiographic recognition of the descending aorta. *Am J Cardiol* 44:232-238, 1979.

7. Joyce JW, Fairbairn JF, Kincaid OW, et al.: Aneurysms of the thoracic aorta—a clinical study with special reference to prognosis. *Circulation* 29:176-181, 1964.

8. Symbas PN: Treatment of thoracic surgical aortic diseases, in Lindsay J Jr, Hurst JW (eds): *The Aorta.* New York, NY, Grune and Stratton, 1979, p. 259.

9. Sahn DJ, Allen DHD: Real-time cross-sectional echocardiographic imaging and measurement of the patent ductus arteriosus in infants and children. *Circulation* 58:343-354, 1978.

10. Haaz WS, Mintz GS, Kotler MN, et al.: Two-dimensional echocardiographic recognition of the descending thoracic aorta: Value in differentiating pericardial from pleural effusion. *Am J Cardiol* 46:739-743, 1980.

11. Osmond GM, Ruttenberg HD, Bessinger FB, et al.: Echocardiographic features of total anomalous venous connection to the coronary sinus. *Am J Cardiol* 41:597-601, 1978.

12. Aziz KV, Paul MH, Barati S, et al.: Echocardiographic features of total anomalous pulmonary venous drainage into the coronary sinus. *Am J Cardiol* 42:108-114, 1978.

13. Kotler MN, Segal BL, Mintz GS, et al.: Pitfalls and limitations of M-mode echocardiography. *Am J Cardiol* 42:108-114, 1978.

14. Green DA, Kleid JJ, Narder S: Unusual echocardiographic manifestation of pericardial effusion. *Am J Cardiol* 39:112-115, 1977.

15. Goh TH, Venables AW: M-mode echocardiogram and abnormal structures behind the left atrium. *Am J Cardiol* 44:575, 1979.

Angina Protection with Benefits for a Lifetime

ONCE-DAILY CONTROL WITH HEART-SAVING BENEFITS

By reducing heart rate and cardiac contractility, INDERAL LA helps protect the heart from the potentially serious and debilitating consequences of ischemia. A highly effective antianginal agent for around-the-clock control of symptoms, INDERAL LA also provides cardiovascular protection for a sense of security in the years ahead.

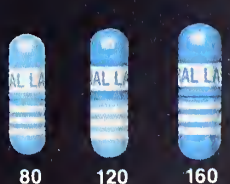
PROTECTION AND EXPERIENCE NO CALCIUM BLOCKER CAN MATCH

Unlike calcium blockers, INDERAL LA—either alone or with a nitrate—is recommended for early treatment of angina in the majority of patients. Equally important, INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use.

START WITH 80 MG ONCE DAILY

Dosage may be increased to 160 mg once daily, as needed, to achieve optimal control. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY **INDERAL® LA**
(PROPRANOLOL HCl) LONG ACTING CAPSULES



Ayerst®

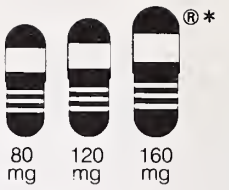
The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

JUST ONCE EACH DAY FOR SIMPLIFIED CORE THERAPY IN ANGINA

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL* LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therap prior to major surgery is controversial. It should be noted, however, that the impaired ability c the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesi and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta receptor agonists and its effects can be reversed by administration of such agents, e.g dobutamine or isoproterenol. However, such patients may be subject to protracted sever hypotension. Difficulty in starting and maintaining the heartbeat has also been reported wit beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the ap pearance of certain premonitory signs and symptoms (pulse rate and pressure changes) o acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be mor difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptom of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have beer reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

8833/384

Ayerst AYERST LABORATORIES
New York, N.Y. 10017

Case Report: Radiographic Findings In Pseudomembranous Colitis

Robert S. Altin, M.D., Long Branch*

Pseudomembranous colitis, an uncommon disorder related to antibiotics, infection, and debilitating conditions, is characterized by a friable, adherent pseudomembrane overlying an edematous and ulcerated mucosa. Radiologic findings in six cases included colonic dilatation and irregularity of the bowel margin (thumbprinting).

Pseudomembranous colitis often is a complication of antibiotic therapy, especially clindamycin.[1] It also occurs in debilitated patients. The mucosal surface is lined with pseudomembrane, which may be either extensive or in isolated plaques.[2]

Between August 1979 and September 1981, six patients had the diagnosis of pseudomembranous colitis made by colonoscopy, autopsy, or surgical specimen. Plain film findings are reviewed in all patients; barium enema was performed in one patient shortly before pseudomembranous colitis was diagnosed.

CASE REPORTS

Case 1: A 71-year-old female presented with abdominal pain and rectal bleeding. Sigmoid biopsy on October 4, 1978, showed pseudomembranous colitis and chronic active colitis. Upper gastrointestinal and small-bowel series one week earlier were negative. Plain film showed thumbprinting of the sigmoid colon (Figure 1). The patient was receiving gentamycin and Cleocin™. Stool culture was negative.

Case 2: A 76-year-old male presented with diarrhea on September 1, 1981. He had sigmoid resection for carcinoma and received Mefoxin® postoperatively. Stool was positive for *Clostridium difficile* toxin on September 4, 1981; sigmoid biopsy showed pseudomembranous colitis on September 11, 1981. Plain film examination showed thumbprinting of the transverse colon (Figure 3) in comparison to earlier normal transverse colon (Figure 2).

Case 3: A 96-year-old male had resection of a sigmoid carcinoma. One month later he presented with diarrhea and was receiving ampicillin. Plain film of the abdomen was not grossly abnormal, but showed subtle thumbprinting of the descending colon. Sigmoid biopsy showed pseudomembranous colitis. Stool culture was negative.

Case 4: An 80-year-old female with a lower gastrointestinal bleeding came to the emergency room. Plain film of the abdomen showed distention of small and large bowel. She became hypotensive and died the same day. Autopsy revealed pseudomembranous colitis. No antibiotic administration was known.

Case 5: A 74-year-old male complained of rectal bleeding. No antibiotics were administered. Barium enema revealed thumbprinting of the descending and sigmoid colon and distention of the transverse and right colon, thought to be typical of ischemic or other colitis. (Figures 4 and 5). Sigmoid resection showed

*Dr. Altin is a Resident, Department of Radiology, Monmouth Medical Center. Correspondence may be addressed to Dr. Altin, Monmouth Medical Center, 300 Second Avenue, Long Branch, NJ 07740.

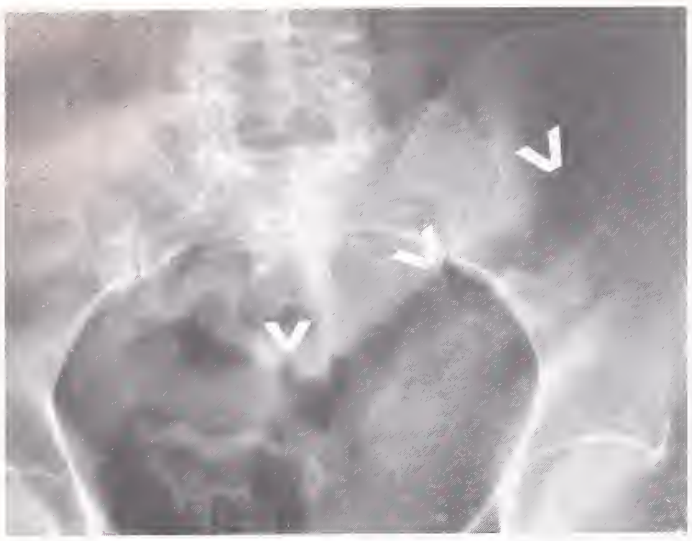


Figure 1—Plain film of the abdomen (case report 1) demonstrates gas within the sigmoid colon (arrowheads). The bowel margin is irregular and shows the broad-based indentations known as thumbprinting.

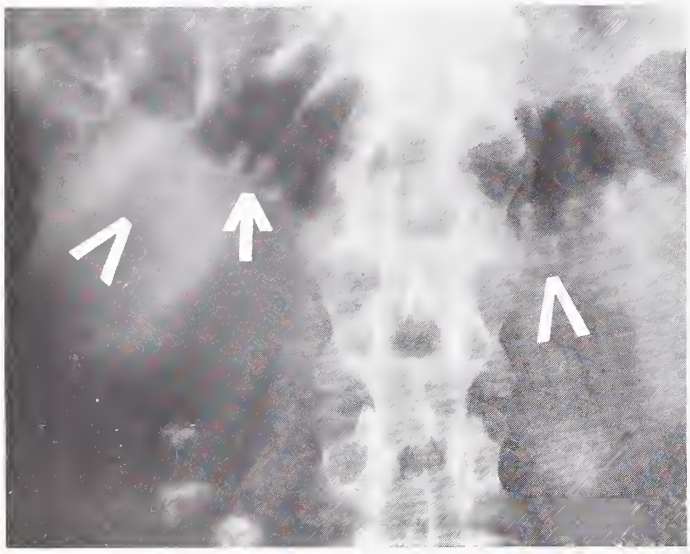


Figure 2—Plain film of the abdomen (case report 2) shortly before sigmoid resections for carcinoma of the colon. Gas is present within the transverse colon (arrowheads) in a normal pattern. The haustral markings are small and smooth (arrow).

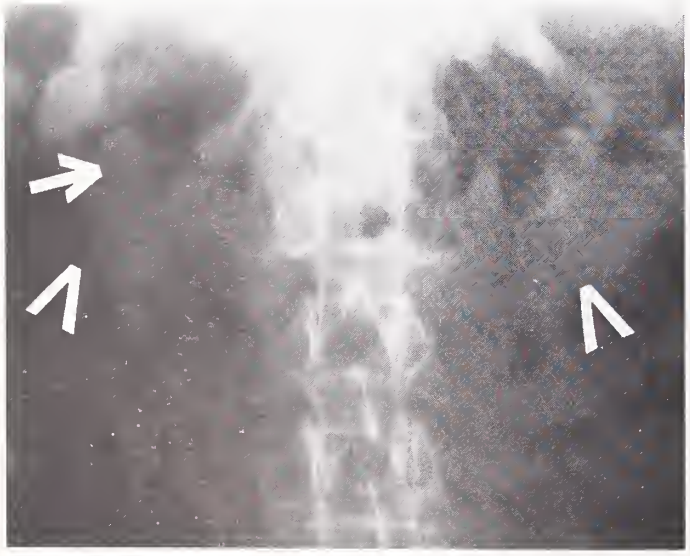


Figure 3—A plain film of the abdomen (case report 3) one month after sigmoid resection. Diarrhea was present about one week. Gas in the transverse colon (arrowheads) demonstrates the large smooth indentations of the colonic margin known as thumbprinting (arrow).

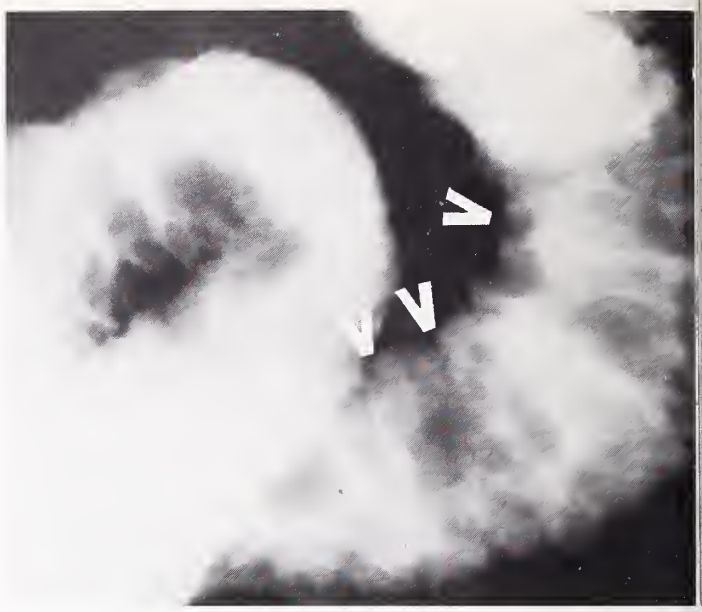


Figure 4—Barium enema (case report 5) performed for rectal bleeding. Closeup of the sigmoid colon shows multiple smooth filling defects of the bowel wall (arrowheads). These are caused by bowel wall edema and represent thumbprinting.

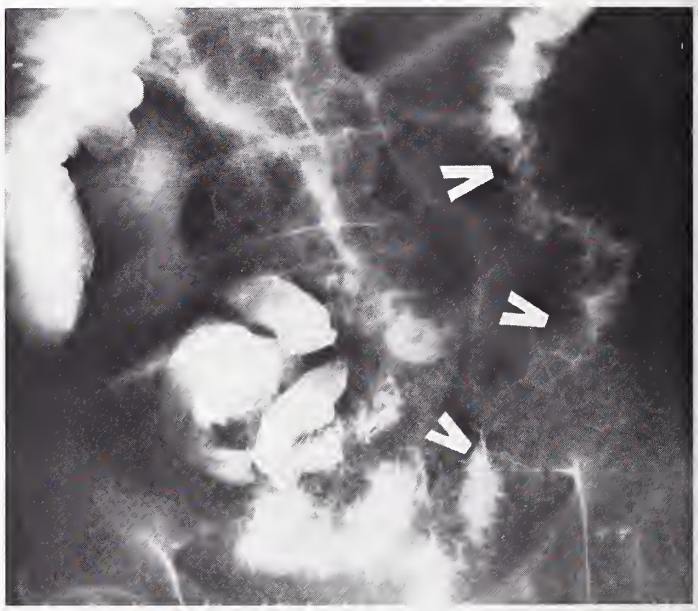


Figure 5—Postevacuation film of the same patient demonstrates irregular mucosa in the sigmoid colon (arrowheads) caused by edema and thickening of the bowel wall.

pseudomembranous colitis. Culture revealed *Escherichia coli*, enterococcus, *Klebsiella pneumoniae*, and *Bacteroides fragilis*.

Case 6: After a right hemicolectomy for carcinoma, cefoxitin was administered. Diarrhea was persistent postoperatively. Plain films of the abdomen showed very slight distention of the colon. Biopsy of the splenic flexure revealed pseudomembranous colitis. Stool culture was positive for *Clostridium difficile*.

DISCUSSION

Plain film findings of pseudomembranous colitis include distention of the small and large bowel, usually colon, thickening of the wall of the colon with wide transverse bands, and thumbprinting.[3]

The small bowel is normally 2 to 3 cm in diameter. Enlargement beyond this size indicates dilatation; however, change in caliber from one portion of the

bowel to another, or change over time, is a better indicator. The colon can vary widely in size. Five cm is about average, and 10 cm is quite dilated, but change in caliber again is a better indicator of local dilatation. Thickening of the bowel wall secondary to edema sometimes will cause separation of loops of bowel. Thumbprinting is a descriptive term given to the smooth indentation of bowel caused by submucosal edema, appearing much like a thumb was pressed against the bowel wall. In the colon the appearance is that of exaggerated haustral markings. Barium enema can show a thin irregular filling defect adjacent to the mucosa, which is described as a shaggy pseudomembrane. Projection of barium outside the mucosal margin indicates ulceration.

Less frequently, pneumatosis is seen (17 percent), as well as toxic megacolon (10 percent). Roentgenograms are negative in 10 percent as well.[2] Pneumatosis (air in the wall of the bowel) usually is seen easily, with a lucent strip of air paralleling the bowel. Toxic megacolon often involves the transverse colon, and is dilated greater than 10 cm in diameter.

Three of our six cases had resection of colon carcinomas shortly before pseudomembranous colitis was diagnosed. All had received antibiotics and presented with diarrhea. Evidence of *Clostridium difficile* was found in two cases. Radiologic plain film findings were subtle. One patient showed slight dilatation of the colon, one patient showed questionable thumbprinting of the descending colon, and the third patient showed thumbprinting of the transverse colon. The striking pattern is that of a recently traumatized bowel in an elderly patient, antibiotic administration, and vague radiologic findings.

Our other three cases all presented with rectal bleeding. None were postoperative. One case received antibiotics. Stool culture in case 5 showed several species, but *Clostridium difficile* was not present. Gross dilatation of small and large bowel was present in case 4 patient, who died shortly after admission secondary to gastrointestinal bleeding. The other two patients had distinct thumbprinting. Barium enema on case 5 patient showed a classical colitis, although pseudomembrane was not definitely seen.

Pseudomembranous colitis frequently is a complication of antibiotic therapy. Early reports implicated clindamycin, but many others have been added to the list, including tetracycline, chloramphenicol, penicillin, ampicillin, and lincomycin.[1] Clinical features include diarrhea, usually without gross blood, pain, distention, and fever. Morbidity and mortality are considerable. Prompt diagnosis is important so that the offending antibiotic can be stopped and vancomycin can be started. In 1978, Bartlett demonstrated *Clostridium difficile* as the cause in antibiotic-related pseudomembranous colitis, and vancomycin the specific treatment.[5]

In the absence of antibiotics, pseudomembranous colitis has been recognized as a complication of surgery, debilitating disease, bowel obstruction, hypotensive or other focal hypoperfusion, uremia, or staphylococcal overgrowth.[1] Small bowel as well as colon can be affected. Edema and thickened mucosa are present and pseudomembrane is found.[2]

SUMMARY

Radiologic findings in our six patients ranged from a barium enema diagnostic of colitis to two patients with only minor findings. Only one patient had a barium enema by which the diagnosis was suggested by the radiology department. Thumbprinting (smooth marginal irregularity secondary to bowel wall edema) was seen in two patients, and was subtle enough in the third to be of questionable significance nonspecific dilatation was seen in one patient, and slight colonic dilatation (shortly postoperative) was noted in another.

A high degree of suspicion is needed to suggest the diagnosis of pseudomembranous colitis. Plain film findings often are subtle. Clinical correlation by the referring physician is critical to rapid diagnosis and treatment. Since many of the patients are debilitated, prompt action may help reduce the high mortality of this disease.

Barium enema is of limited usefulness. It can be dangerous if the colon is dilated and rarely demonstrates a pseudomembrane. Sigmoidoscopy or colonoscopy usually is diagnostic.

REFERENCES

1. Stanley RJ, et al.: The spectrum of radiographic findings in antiobiotic-related pseudomembranous colitis. *Radiology* 111:519-524, 1974.

2. Tully TE, Feinberg SB: Those other types of enterocolitis. *Am J Radiol* 121:291-299, 1974.

3. Stanley RJ, et al.: Plain film findings in severe pseudomembranous colitis. *Radiology* 118:7-11, 1976.

4. Tully TE, Feinberg SB: A reappearance of antibiotic-induced pseudomembranous colitis. *Radiology* 110:563-567, 1974.

5. Bartlett JG, Gorbach SL: Antibiotic-associated pseudomembranous colitis due to toxin-producing clostridia. *N Engl J Med* 298:531:538, 1978.

6. Schapiro RL, Newman A: Acute enterocolitis. *Radiology* 108:263-538, 1978.

WHY AMA?

The AMA provides a democratic forum where you, along with your colleagues across the country, can raise and argue issues, reach a consensus and formulate policy. AMA policy is then translated into practical actions on issues that affect you and your practice. Making sure medicine stays active, strong and united: it's one more good reason why you should be a part of the AMA.

To Join,
Contact your county or state medical society or write: Division of Membership, AMA, 535 North Dearborn Street, Chicago, Illinois 60610 or call collect, (312) 751-6196.

AMA
AMERICAN MEDICAL ASSOCIATION

WHY AMA?

The AMA has actively sought to attract women as members and leaders in organized medicine. Ongoing AMA projects and concentrated efforts by county, state, and specialty societies have significantly increased the leadership role and membership of women in organized medicine. Strengthening the voice of women in medicine through encouraging active participation: it's one more good reason why you should be a part of the AMA.

To Join,
Contact your county or state medical society or write: Division of Membership, AMA, 535 North Dearborn Street, Chicago, Illinois 60610 or call collect, (312) 751-6196.

AMA
AMERICAN MEDICAL ASSOCIATION

References:
1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Us

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for th management of vasospastic angina confirmed by any of the following criteria: 1) classical patter of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm pro voked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patient who have had angiography, the presence of significant fixed obstructive disease is not incompatibl with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDI may also be used where the clinical presentation suggests a possible vasospastic component bu where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion o in unstable angina where electrocardiographic findings are compatible with intermittent vaso spasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated fo the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrate or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlle trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance but confirmation of sustained effectiveness and evaluation of long-term safety in those patients ar incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available infor mation is not sufficient to predict with confidence the effects of concurrent treatment, especially i patients with compromised left ventricular function or cardiac conduction abnormalities. When in troducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect o PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tol erated hypotension. These responses have usually occurred during initial titration or at the time o subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, du ration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mech anism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a with drawal syndrome with increased angina, probably related to increased sensitivity to catechol amines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vaso dilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request. © 1982, Pfizer Inc.

Pfizer LABORATORIES DIVISION
PFIZER INC

"I can do things that I couldn't do for 3 yrs. including joining the human race again."



Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

1983, Pfizer Inc.

"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA *brief summary on adjoining page.*

COMMENTARY: WHATEVER HAPPENED TO BENIGN NEGLECT?

MICHAEL A. NEVINS, M.D., WOODCLIFF LAKE*

Two cases in New Jersey courts may have a profound effect on how much autonomy physicians will be permitted in making critical decisions for chronically ill patients. In the process, the tradition of benign neglect has taken on an unfortunate connotation; a more appropriate designation would be therapeutic restraint.

A century ago, Sir William Osler's famous characterization of pneumonia as "the old man's friend" was a serene acknowledgement of nature's way. In that more innocent time, treatment options were few; now the modern physician has acquired a plethora of potent therapeutic agents along with previously unthinkable moral and legal dilemmas. One wonders what Osler would have thought of the recent spectacle depicted in the national press and on television of two California physicians tried for murder after having terminated respirator and feeding systems for a comatose patient with the consent of responsible family members. Closer to home, what would Osler have thought about two rulings by New Jersey courts in 1983 which have substantially extended concern about the legal implications of medical decision making away from relatively uncommon cases of brain death or coma and closer to the routine practice of primary care physicians. Both cases involved elderly institutionalized patients who had chronic but not "terminal" illness and clinical decisions involved judgments concerning the quality of life. A review of some features of these important cases is instructive.

THE CLAIRE CONROY CASE

In this case (*Conroy*, 188 N.J. Super. 523 (1983)), Judge Reginald Stanton of the State Superior Court, Chancery Division of Essex County, decided on February 2, 1983, that a nasogastric tube could be removed from an 84-year-old nursing home patient who suffered from a severe organic brain syndrome and who was totally dependent upon the tube for nutrition. The patient had severe dementia, required total care, had a gangrenous foot, lay virtually immobile in a fetal position, was mute except to moan when stimulated, and weighed less than 50 pounds. Miss Conroy's guardian had petitioned to permit the nursing home to remove the feeding tube. The court order was not carried out because opponents won an immediate stay, but Miss Conroy died of natural causes 13 days later.

At issue is the question: At what point can a patient, or someone acting in his/her behalf, refuse basic treatment? Judge Stanton, fully aware of the significance of his action, in a moving analysis noted the following:

"Life is our most basic possession. The will to stay alive probably is our strongest instinctive drive. As a general proposition, the protection of life is one of the law's strongest imperatives, and preservation of life is the major goal of medical practice. The interest of the state in preserving life is so great that courts have ordered medical procedures to be performed on patients even though the patients were competent and had objected to the procedure. In these cases, however,

*Dr. Nevins is Governor, New Jersey Chapter, American College of Physicians. Correspondence may be addressed to Dr. Nevins, 595 Chestnut Ridge Road, Woodcliff Lake, NJ 07675.

the expectation is that the patient will have a reasonably full and vibrant life after the treatment has been performed. There is a point at which a patient, or someone acting for him if he is incompetent, has a right to refuse treatment. That point is reached when intellectual functioning is reduced permanently to a very primitive level or when pain has become unbearable and unrelievable.

"When we deal with questions such as the ones presented in this case, a certain basic humility and a sense of one's own limitations are appropriate. We know that mankind's understanding of the ultimate meaning of life, suffering, and death, is (and probably always will be) flawed and limited. Many of us believe that an abiding reverence for life is perhaps our most special and most worthy human characteristic, but most of us would agree that when a person has been permanently reduced to a very primitive intellectual level or one is permanently suffering from unbearable and unrelievable pain there is no valid human purpose to be served by employing active treatment designed to prolong life. Every sick human being is entitled to loving care, but there comes a time in the loving care of some patients when the proper decision is to let nature take its course, to allow the patient to die.

"Even when we decide that it is proper to withhold active treatment, it would be wrong to act directly to terminate life or to withdraw nourishment, fluids, shelter, or normal supportive care such as washing and body positioning. When I say that it would be wrong to withdraw nourishment and fluids, I mean that it would be wrong to refuse to give them to the patient if she could take them herself or with the manual assistance of others. It also would be wrong to withhold medications which would reduce pain without unduly prolonging life. I conclude that these things would be wrong because I perceive a need in this area of decision making: 1) to recognize the limitations of our understanding of life, suffering, and death; 2) to continue a fundamental respect for life even in the most dire human circumstances; and 3) to keep in place some fairly simple conceptual controls designed to give some measure of protection against ill-informed or badly motivated decisions."

Judge Stanton felt that, in this instance, the feeding tube constituted an extraordinary means of treatment. He acknowledged, however, that although distinctions between extraordinary and ordinary frequently are made, such terminology is not helpful and the critical factor should be the present condition and prognosis of the patient, focusing on whether life has become, and is likely to remain, impossibly burdensome to that patient. He noted further, "Once we human beings start making choices, we start making mistakes. It is inevitable that we allow some people to die when we could have and should have prolonged their lives. But we cannot let this fear of error force us into abdicating our basic human responsibility to make choices. The fear of error should be used constructively as an incentive to make our choices carefully and soundly." He also observed that it would be inappropriate to extrapolate from this case to the treatment of elderly senile patients or retarded persons of all ages in general, but that careful distinctions had to be made.

Although Claire Conroy already had died, on July 8, 1983, the Appellate Division of the State Superior Court, noting the precedent-setting implications of the Conroy case, reversed the lower court order. They distinguished Claire Conroy from Karen Quinlan in that the former neither was in a coma nor in a persistent vegetative state finding that Miss Conroy still had many signs of life and that removal of the feeding tube would inflict new suffering and pain. They felt that rather than easing her passage from life, removing the tube would have represented active euthanasia rather than merely letting die.

It is possible that the Conroy case will be appealed to the State Supreme Court. The New Jersey Hospital Association has argued that the Appellate Court ruling undermines safeguards of local hospital review already established under the post-Karen Quinlan guidelines and, thereby, favors increased judicial involvement in such cases.[1]

The following should be noted in relation to the Quinlan case:

1. The ruling permitted the removal of life-support devices, but did not distinguish between respirators and artificial feeding systems. It should be recalled that it was expected that Karen would die as a result of turning off the respirator. When she did not, her family chose not to follow through with the next logical step of terminating artificial feeding, but this was their choice rather than a legal sanction.

2. The language employed created much confusion. The Quinlan guidelines were intended for the use of a patient in a coma although there was and continues to be some question about whether Karen was in a coma, a stupor, or a chronic vegetative state. In any case, the guidelines did not apply to cases of brain death.

3. The guidelines suggested the formation of prognosis committees or the like, the intention of which was to verify the clinical prognosis. Curiously, the composition of such committees heavily favored lay people who would seem to be unqualified to make such clinical determinations. The ultimate decision-making responsibility remained with the attending physician.

4. The guidelines were only guidelines and pertained not only to hospitals, but to "health facilities."

As a result of these ambiguities and legal jargon, implementation of the Quinlan guidelines has varied in each of the state's 101 acute hospitals. Indeed, the number of hospitals which currently have functioning prognosis committees is uncertain. Two recent surveys, using different methodology, have suggested that between 50 and 84 percent have a formal mechanism that can be activated which is substantially more than the results of recent national surveys which have indicated between 1 and 4 percent of hospitals in the United States have prognosis or ethics committees.*

The position of the New Jersey Hospital Association relative to the Conroy case is that it would be regressive to return such responsibility to the courts since the majority of hospitals in New Jersey already have a functional mechanism that is utilized in cases of terminating life support according to the Quinlan guidelines.

*Personal communications.

The Appellate Court apparently rejected this logic on the basis that Miss Conroy demonstrated sufficient signs of life that she was not in the same terminal condition as Karen Quinlan. Recall that Miss Conroy, despite artificial feeding, had wasted to less than 50 pounds and was considered to be in an irreversible state responding only to noxious stimuli. When visited by Judge Stanton, she was found to be functioning at a "near zero level." Indeed, she died within two weeks with the tube still in place. Incredibly, the Appellate Court's conclusion that Miss Conroy was not facing imminent death was made even though she had died five months before their decision was announced. Furthermore, having made this distinction, the Appellate Court introduced emotional language to suggest that death by dehydration increases suffering albeit the tube itself and prolongation of the process of dying might similarly cause discomfort.

Every sick human being is entitled to loving care, but there comes a time when the proper decision is to let nature take its course.

The Conroy case is bad news for physicians regardless of future court actions. If the Appellate Court ruling stands, the case represents a step back from Quinlan and makes it virtually impossible to reasonably distinguish on the basis of the nuances that the court was able to perceive between the conditions of patients such as Karen Quinlan and Claire Conroy. It guarantees that the legal system will become increasingly involved in decision making in these already difficult cases. On the other hand, if the case is challenged and the Appellate ruling overruled, although this would reinforce and clarify the Quinlan decision, emphasis inevitably will be put on more active involvement of cumbersome prognosis committees in hospitals and, perhaps, even in nursing homes, with a resultant diffusion of the traditional decision-making process. Further impetus for this trend already has emerged as a result of publicity attendant to the "Baby Doe case"[2,3] as well as the recent recommendation of the President's Commission on Biomedical Ethics.[4]

THE GRECO CASE

The President's Commission had acknowledged that in health care "it is common to make decisions that one knows risk shortening patients' lives and that sometimes turn out to do so." These often are regarded as cases of "allowing to die" or "not prolonging the dying process" as distinguished from killing or hastening death.

Contrasted to the Conroy case, the Greco case (*Greco* OAL DKT No. BDS 5098-81 (1982)), in effect, involved extension of the concept of letting die now not by withholding nutrition, but by being insufficiently vigorous in pursuing medical treatment for patients the court felt were not terminal enough.

Dr. Roger Greco, a nursing home medical director, had his medical license suspended for one year by the State Board of Medical Examiners because he was found not to be zealous enough in hospitalizing or treating elderly nursing home patients who technically were not suffering from terminal illnesses when they developed superimposed acute medical illnesses. In the opinion of the Board, this was a deviation from standard care and, as such, represented repeated acts of negligence, malpractice, or incompetence.

Of the six cases reviewed in detail, Dr. Greco was exonerated in all but two cases. One of these cases was an 88-year-old woman who was confused and out of contact with reality, had one kidney and chronic renal failure, and required total care. The clinical records indicated that she developed pneumonia which, in turn, exacerbated her renal failure, diabetes, and heart failure. The patient was not abandoned, but therapy was initiated at the nursing home where she died after five days. At one point in the testimony, Dr. Greco suggested that it was his feeling that it would have been better to "let her die in peace" than to hospitalize her for more aggressive therapy. Several medical witnesses, however, felt that supportive care in such a circumstance was inappropriate since the acute illness was potentially reversible without using extraordinarily invasive measures and that the patient was not in a vegetative state, although she required total care, was incontinent, and responded to most questions only with moans.

The Greco case presently is being appealed, but its implications are ominous. It was conceded that the physician was conscientious and was using his best judgment even though some considered that judgment to be flawed. Although the testimony of several expert medical witnesses indicated that he deviated from standard care, it is hard to understand how there can be any real standards in such cases. If there were, they should be applied to patients in the context of their total condition and not to an acute disease per se. However, Judge Sybil Moses did not acknowledge such a distinction between patient and disease orientation. She suggested that to offer less than total care unless the patient is truly vegetative, in agony or imminently terminal, is inappropriate and that treatment for comfort rather than curing goals, while appropriate in a hospice, is not applicable in a nursing home.

Commenting on the issues of "death with dignity" or "hospice philosophy" which place into issue the question of passive euthanasia and the assertion of "a right to die," Judge Moses said:

"This judge is absolutely certain that such a right to die must be part of an indication of persons who through some act on their own make their intention known. Since the New Jersey legislature has not enacted a natural death act and since none of the patients in question has enacted any type of living will, this philosophy is inappropriate to the facts of this case. Furthermore, the assertion of a hospice philosophy as the standard of care does not have a foundation of fact. Hospice care in the United States presently is provided at designated centers specifically recognized as providing this particular treatment. The proofs before this judge do not demonstrate that (the nursing home in question) operated pursuant to this

	Agree*	Strongly Agree	Strongly Disagree
1. The physician should deliver the best care possible at the nursing home with major emphasis on comfort goals. Although the home's facilities are relatively limited, acute hospitalization is inappropriate under the circumstances.	70%	52%	3%
2. The physician has a right and duty to act independently in what he believes to be the patient's best interest as he understands them, there being no identifiable family with whom to consult.	75%	48%	3%
3. She should be treated the same as any younger patient and admitted to an acute hospital for aggressive diagnosis and treatment.	13%	8%	26%
4. Decision making would be enhanced by consultation with a local committee or court.	10%	6%	32%

*Includes "agree" and "strongly agree."

Figure—Questionnaire mailed by the New Jersey Chapter, American College of Physicians.

philosophy or had the prior consent of these patients to withhold the type of treatment suggested by the state's experts."

DISCUSSION

Where do the Conroy and Greco cases leave us? It is disconcerting that even with family concurrence or with court approval there are no legal guarantees and so the prudent physician is best advised to proceed with extreme caution. The courts have ruled that it is a competent patient's right to refuse treatment and it is our responsibility to respect and strive to preserve those rights. Yet, the proper direction to proceed often is unclear.

In such cases, much confusion would be averted if physicians adhered to precise usage of terms, such as "unconscious," "stupor," "coma," "responsive," "terminal," and "brain dead." Fine distinctions that seem irrelevant or unnecessary at the bedside may prove to be crueial in effecting a verdict in court.

Regarding terminating artificial feeding, as a result of the Conroy case, unless a patient is brain dead, comatose, or death is irreversibly imminent, discontinuing nutrition is not permissible. However, even when these criteria are met, whether the decision can be made by physician, committee, or court in New Jersey, will depend on future appeal of the Conroy case. Many physicians have found that it is easier, in a legal sense, not to initiate tube or intravenous feeding although morally the distinction between not beginning and removing is unclear.[4] The propriety of not starting artificial feeding is still to be tested in the courts.

For patients who are not considered to be moribund, but who exist in an extremely limited vegetative state, it is unlikely that society ever will arrive at a normative standard of care.

In July 1983, in order to assess New Jersey physicians' attitudes, a questionnaire was mailed to members of the state's chapter of the American College of Physicians inquiring how they would react to a fictitious case that simulated some cases encountered by Dr. Greco. Results were compiled from the first 202 replies which constituted more than 10 percent of the organization's members. There was little variation between the responses of office-based practitioners, academicians, or house staff.

The following was the model case: An 85-year-old woman with no close family resides permanently in a nursing home. She suffers from Alzheimer's disease as well as several chronic disabilities that make her dependent on others for total care. She develops a superimposed acute infection and no longer is eating nor is as responsive as before. The questionnaire then invited responses to four statements (Figure).

Despite the pitfalls of interpreting such an opinion survey, it is evident that New Jersey internists consider age and general condition to be important determinants of the intensity of care. Recognizing that individualization is requisite to good care and believing that increased involvement of courts and committees into bedside decision making is regressive, the Council of the New Jersey American College of Physicians as well as the New Jersey Society of Internal Medicine adopted the following statement:

> The extent of treatment to be rendered to an acutely ill geriatric patient remains a subject of considerable debate within the medical community. To date, there are no generally accepted standards by which a physician may be guided. Since no such standards currently exist, it is the position of the New Jersey Chapter of the American College of Physicians that no physician should be disciplined for providing supportive care, rather than aggressive care, when treating acutely ill geriatric patients or, in the alternative, aggressive care rather than supportive care. Any government imposed standard on this issue would, at this time, result in severe hardship upon geriatric patients and their families. The NJ-ACP strongly opposes the imposition of such a government standard by any regulatory body absent a full and complete review of this most important question.

Most physicians agree that in many cases when acute illness supervenes it may be more compassionate and sensible to do what can be done in the context of home or nursing home even though the technical therapeutic capabilities there are less than

those available in the acute hospital. Such a decision to pursue limited therapeutic goals rightfully should be made jointly by physician and family since the rhythms of court and committee are incompatible with bedside decision making.[6]

Much has been written about how and by whom ethical dilemmas in caring for the ill should be undertaken.[4,7-13] Mechanisms involving predetermined contracts or decisions by consensus generally are impractical and present problems of logistics, professional expertise, and objectivity. In the end, the best safeguard to maintaining patients' rights is and always has been a compassionate and legally unencumbered physician who has reasonable discretion to act in the patients' best interests as he understands them and who sees his responsibility as not only to take care of his patients but to care about them.

It is a fact of medical practice that physicians regularly are involved with decisions that have life and death implications and unless they are willing to assume the responsibility to act in their patient's behalf when that patient cannot participate in the process, they are not really doing their jobs. As Dr. Arnold Relman has remarked, "God protect us from physicians who make only technical decisions." In caring for the elderly senile and the retarded, one must be particularly careful about premature withdrawal or denial of treatment. Many who suffer from markedly impaired intellects may be capable of loving and responding to love. Whereas it is reprehensible to deny treatment on the basis of the patient's age or illness, to suggest that there is or ever was or ever can be a single standard of care irrespective of age is misguided. For example, it is ludicrous to contemplate performing an invasive procedure such as coronary artery bypass surgery in a wasted, demented, barely functional patient. Subjective distinctions always have been implicit in the weighing of risks and benefits that constitute clinical medical practice. Nontreatment or limited treatment is not a corruption, but perhaps the highest form of what commonly is referred to as the "art of medicine." However, in recent years the venerable tradition of "benign neglect" has taken on an unfortunate connotation. It should not denote either negligence or abandonment and perhaps a more appropriate designation would be "therapeutic restraint."

It is unfortunate that sanctioning such a policy of therapeutic restraint should be considered as akin to "a moral domino effect" or a "slippery slope"[4] that inevitably would lead to abuse. Rather, the converse is more to be feared, of relentlessly doing all for fear of being criticized for being nihilistic or negligent. Yet, the Appeals Court in the Conroy case raised this spector stating: "To allow a physician or a family member to disconnect life-sustaining treatment to a person solely because that person's lack of intellectual capacity precludes her from enjoying a meaningful quality of life would establish a dangerous precedent that logically could be extended far beyond the facts of a case before us."

Fundamental to caring for chronically ill nursing home patients is that decision making be oriented to maintenance of function and comfort.[13] Limited goals and therapeutic restraint clearly are not the exclusive prerogatives of hospices and are applicable in some cases even when the patient technically is not terminally ill.

Beset by existential and legal doubts, the physician rarely has the luxury of time to agonize, Hamlet-like, about the proper course of action. I have always believed that the best advice for the perplexed clinician is that of the first century sage Hillel, who when asked to teach the Torah "while standing on one foot," replied, "What is hateful to you, do not unto your neighbor; this is the entire Torah, all the rest is commentary." Would Hillel have been found guilty of malpractice?

REFERENCES

1. Brennan MK: The right to die is still unclear. *New York Times*, August 28, 1983.
2. Wallace C: Outcry over "Baby Doe" may revive little-used hospital ethics committee. *Modern Healthcare* 13:79-80, 1983.
3. Strain JE: The American Academy of Pediatrics comments on the "Baby Doe II" regulations. *N Engl J Med* 309:443-444, 1983.
4. President's Commission For The Study of Ethical Problems In Medicine and Biomedical and Behavioral Research: Deciding to forego life-sustaining treatment. Washington, D.C., U.S. Government Printing Office. 1982.
5. Williams ME, Hadler NM: The illness as the focus of geriatric medicine. *N Engl J Med* 308:1357-1359, 1983.
6. Marco CH: For whom the death bell tolls: Who shall live, who shall die, who shall toll the bell? *Legal Aspects Medical Practice* 11:3-8, 1983.
7. Micetich KC, Steinecker PH, Thomasma DC: Are intravenous fluids morally required for a dying patient? *Arch Intern Med* 143:975-978, 1983.
8. Suber DG, Tabor WJ: Withholding of life-sustaining treatment from the terminally ill, incompetent patient: Who decides? *JAMA* 248:2250-2251, 2431-2432, 1982.
9. Childress JF: Who should decide? in, *Paternalism in Health Care*. Oxford University Press, New York, NY, 1983.
10. Meier DE, Cassel CK: Euthanasia in old age: A case study and ethical analysis. *J Am Geriatr Soc* 31:294-298, 1983.
11. Pearlman RA, Speer JB: Quality-of-life considerations in geriatric care. *J Am Geriatr Soc* 31:113-120, 1983.
12. Kass LR: Ethical dilemmas in the care of the ill. *JAMA* 244:1811-1816, 1980.
13. Besdine RW: Decisions to withhold treatment from nursing home residents. *J Am Geriatr Soc*, October 1983.

It's about time you had a real professional assist you in attaining your personal, practice and retirement investment goals.

Dr. S. Randy Sarantos is that professional.



A doctor with over 20 years of financial experience, who is now a full-time Registered Investment Advisor and financial planner counseling health care professionals, Dr. Sarantos understands the special problems you face in developing your personal estate plan, managing your practice economic goals, planning for your retirement, and investing your pension assets.

Dr. Sarantos is a member of the International Association of Financial Planners and is licensed through Investment, Management & Research, Inc., member National Association of Securities Dealers and Security Investors Protection Corporation and an affiliate of Raymond, James & Associates, Inc., member New York Stock Exchange, in the securities, tax shelter, commodities and insurance investment areas.

For a confidential consultation with Dr. Sarantos, please call or return the coupon below today. He is ready to answer the many diverse financial questions that probably only *another* health sciences professional can effectively answer.

Dr. Sarantos:
Please contact me regarding the following area of interest:

☐ Developing a financial plan
☐ Investment management
☐ Tax shelter planning
☐ Insurance review
☐ Retirement plan review
☐ Practice management review

Name _____

Address _____

City/State/Zip _____

Office Phone ___/_____ Home Phone ___/_____

Call 800-223-0164
or 201-539-4000 (NJ only)

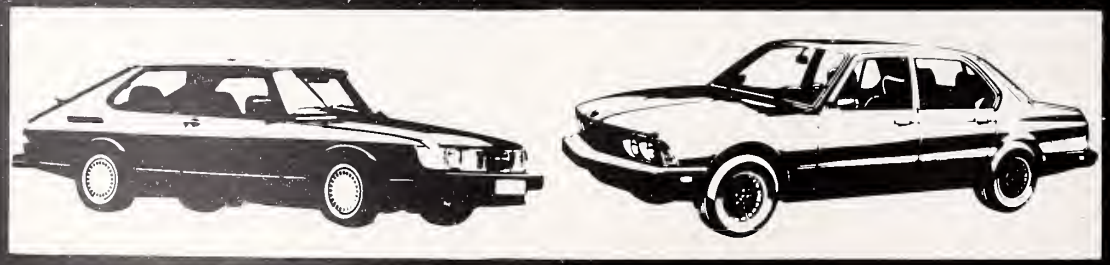
SARANTOS & LANSING FINANCIAL SERVICES, INC.
240 Cedar Knolls Rd., Cedar Knolls, NJ 07927

JMK

BMW

SAAB

Our reputation has been built on our SERVICE



JMK AUTO SALES

391 Rt. 22 (East) Springfield, New Jersey

379-7744

COMMENTARY: THE CONROY CASE

HARVEY ROTHBERG, M.D., PRINCETON*

Further judicial review should clarify the issues in this recent New Jersey case, and provide appropriate guidelines for the management of similar cases. Issues include quality of life, ordinary versus extraordinary care, and whose is the decision-making responsibility.

New Jersey physicians should be familiar with the Conroy case and aware of its implications.[1-4]

Claire C. Conroy was an 84-year-old spinster who had a severe organic brain syndrome, as a result of which she was declared incompetent and she entered Parklane Nursing Home in 1979. She became bedridden and unable to feed herself; she became unable to converse, although it was said that she could respond to commands. She developed necrotic ulcers on her left foot which were attributed to diabetes. In July 1982, her physician at Parklane ordered the placement of a nasogastric feeding tube in Miss Conroy; it was felt that she was unable to swallow sufficient food or water to live without such a device. Subsequently, Miss Conroy's condition deteriorated further. She lay in bed in a fetal position and developed decubitus ulcers on her left leg and left hip. Despite the feeding tube, she became wasted and her weight was less than 50 pounds. She became unable to communicate except to moan in response to noxious stimuli, and it was uncertain whether she could experience pain as such.

Her only surviving relative, her nephew and guardian, sought to have the tube removed, but the attending physician would not consent to this. In January 1983, the nephew filed a complaint which was brought before Judge Reginald Stanton of the Essex County Chancery Division of the Superior Court of New Jersey. Judge Stanton appointed a lawyer to be guardian ad litem for Miss Conroy. He also observed the patient in the nursing home and heard testimony from two physicians, from the nurse-administrator of the nursing home, from the nephew, and from Father Joseph Kikura, a member of the medical ethics committee at four hospitals and an associate professor of Christian ethics.

Judge Stanton in his opinion dated February 2, 1983, noted that Miss Conroy's life had become permanently burdensome for her and that prolonging her life would not help her. He affirmed the right of her nephew and guardian to direct the removal of the nasogastric tube. However, Judge Stanton's decision promptly was appealed by the court-appointed lawyer, and the tube was not removed. Nevertheless the patient expired of natural causes 13 days later.

Even though the death of the patient rendered the case moot, the Appellate Division chose to continue its review of the matter because of the importance of the issues presented. The Appellate Court reversed Judge Stanton's decision, holding (in its concluding statement) that a patient such as the deceased should not be painfully put to death by dehydration and starvation.

In the Appellate Court hearings, Ms. Mary K. Bren-

*Dr. Rothberg is a member of the Princeton Medical Group. Correspondence may be addressed to Dr. Rothberg, Medical Arts Building, Suite B, Witherspoon and Franklin Streets, Princeton, NJ 08540.

nan argued the case for amicus curiae New Jersey Hospital Association; they sought to have Judge Stanton's decision affirmed. The Medical Society was not involved officially in the proceedings. Now, the New Jersey Hospital Association has moved the case for further appeal to the New Jersey Supreme Court. It is expected that the Supreme Court will consider thoroughly all the facts as well as the complex issues involved in order to render a considered judgment in the matter.

It is essential that the decision of the Appellate Division be reversed, so that patients, families, and physicians may have restored to them the options which naturally and traditionally have belonged to them.

There are at least four major areas in which the reasoning of the Appellate Court can be questioned. First, a major error was the dubious presumption that the removal of the nasogastric feeding tube would inevitably have led to pain and suffering for the patient. From the clinical point of view, it seems far more likely that this stuporous patient would instead have gradually lapsed into a coma and expired quietly without pain or suffering.

Secondly, there is the question of ordinary and extraordinary care. The opinion of the Appellate Court does address this question at some length, but it declines to resolve the issue. However, what is clear is that the terms ordinary and extraordinary are relative. What is "ordinary" treatment for a young, vigorous, and potentially rehabilitatable individual may be "extraordinary" for another individual whose mental and physical status have deteriorated irreversibly, whose quality of life is poor, who is not rehabilitatable, and who is near the end of his or her life. It is arguable that the use of a nasogastric feeding tube for a patient such as Miss Conroy might have been construed by the patient or her guardian or her physician as extraordinary and inappropriate under the circumstances.

Contrary to the reasoning of the Appellate Court, I believe that the removal of a nasogastric feeding tube in a case like this is not a positive act which intentionally causes death, but rather the removal of an inappropriate modality of treatment thereby permitting the patient to expire naturally. Thus, removal of the tube in this case would not be an act of euthanasia, and would not create a potentially dangerous precedent.

The third question deals with the decision-making responsibility. A medical decision is normally made by a sentient and informed patient in conjunction with his or her physician. When the patient is unable to express himself or to participate in the decision, then his family must act on his behalf in conjunction with the physician. (In emergency situations, the physician may have to act on behalf of the patient without full consultation.) Only in the exceptional cases where a conflict or disagreement exists between the normally deciding parties should it be necessary to have judicial intervention. A serious defect of the Appellate Court decision in the Conroy case, if it stands, would be the removal from families and physicians of some of the freedom and the options which now are available to them in their search for the most appropriate and compassionate means of care of patients for whom they are concerned.

Parenthetically, it should be noted that the physician does have a great responsibility in such situations, yet he must remember that the responsibility is not his alone. He is not God. He must be careful not to project his own feelings or his own culture into the lives of people with different persuasions. The physician's role often enough is to decide and to act; but frequently it primarily is to counsel, to guide, and to provide information so as to aid a patient or his family to make the decisions which are appropriate for them.[5,6]

A fourth area of confusion in the Conroy case discussions concerns the question of what constitutes a terminally ill patient. The Appellate Court decision states that Miss Conroy was not terminally ill and suffered from no specific life-threatening illnesses. This conclusion is highly questionable. It is true that Miss Conroy did not have cancer or refractory heart, lung, or kidney failure; but she did have extreme malnutrition, inanition, wasting, decubitus ulcerations, and a deteriorated mental and physical state. The expression "terminal" as applied to advanced illness means only that the patient is at or near the end of his course and of his life. Such a definition could certainly be appropriately applied to Miss Conroy, who in fact expired just 13 days after Judge Stanton's decision. (But I do not wish to consider this area of confusion as a governing consideration in the case, because it may well be held that the question of removal of the feeding tube is not necessarily related to the question of whether the patient is or is not in a terminal state.)

Until now we have had in medicine an ethical but flexible system in which a patient's relatives and physician have been able to make decisions on behalf of a patient and in his best interests as they construe it. The Appellate Court's decision in Conroy would create a restrictive system in which medical options are limited. In such a system, technology could easily have a higher value than the humanitarian concerns which traditionally have operated in the practice of medicine.

That such a flexible or permissive system is accepted in our society is implicit in the March 1983 report of the President's Commission for the Study of Ethical Problems in Medicine, entitled, *Deciding to Forego Life-Sustaining Treatment.*[7] This superbly conceived and documented publication represents a balanced consensus of informed opinion on the issues considered, and it should be required reading for anyone wishing to be well informed on the subject. The Commission notes that "the primary goal of health care in general is to maximize each patient's well-being." In discussing the concept of allowing patients to die, the Commission states its belief that "most omissions that lead to death in medical practice are acceptable." The Commission concluded that ordinarily a patient's surrogate "should have the legal authority to make decisions on behalf of an incapacitated patient," and it noted further that such "decisions made by surrogates and physicians now are rarely subjected to court review."

Experienced and perceptive physicians engaged in the active practice of medicine are well aware that

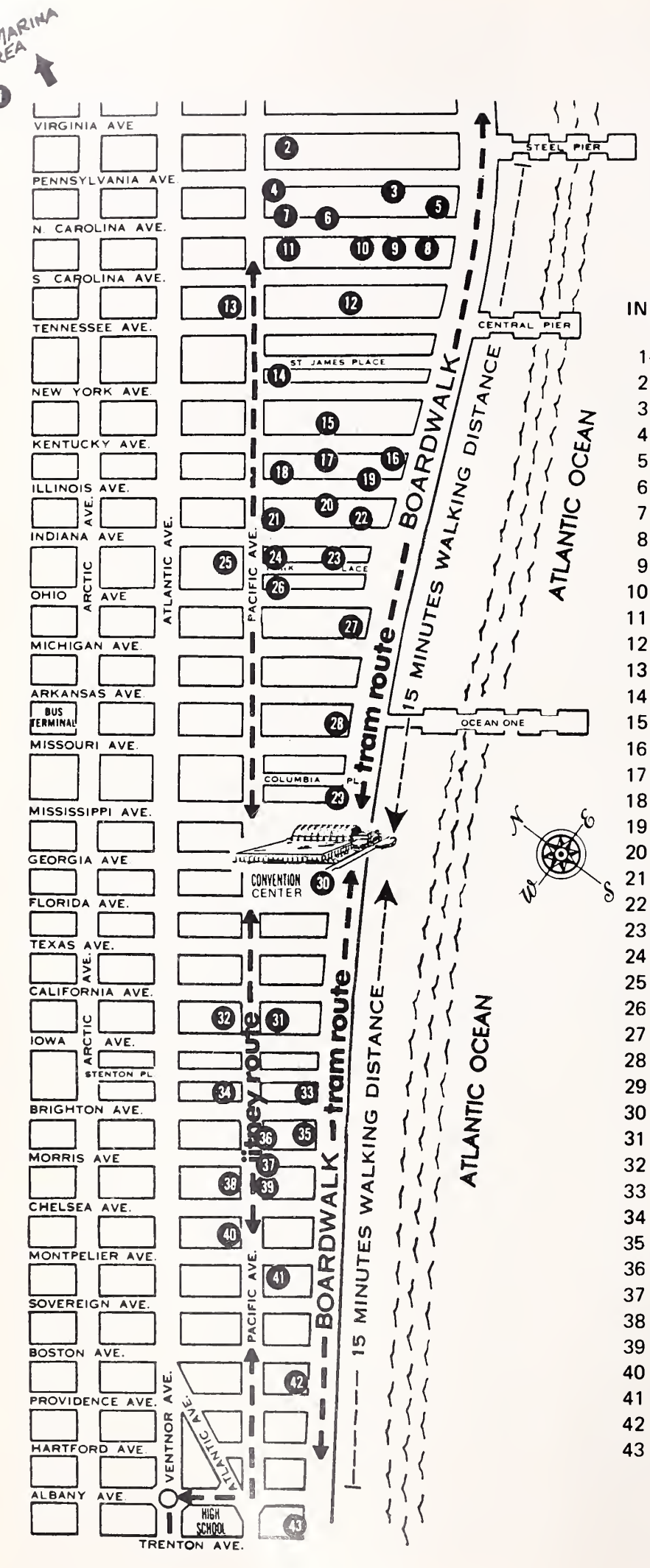
clinical decisions comparable to that exemplified in the Conroy case are made every week—if not every day—in American hospitals. Affirmation of the dubious principles enounced by the Appellate Court would undoubtedly change medical management in some cases; but it also would invite flouting the law in others. Many concerned and loving families and compassionate physicians would continue to be guided primarily by their concepts of what is right and proper for the patient for whom they are caring.

CONCLUSION

For all the above reasons, I believe that the wisdom and humane concern manifest in the Quinlan decision and in Judge Stanton's opinion should be reaffirmed; and the Appellate Court ruling in the matter of Conroy should be recognized as a flawed and invalid document which ought not to be permitted to stand as a restraint on the provision of humane and appropriate care for the citizens of New Jersey.

REFERENCES

1. *Claire C. Conroy*, Superior Court of New Jersey, Chancery Division, Essex County Docket No. P-19083E. Rendered by Judge Reginald Stanton.
2. *Claire C. Conroy*, Superior Court of New Jersey, Appellate Division, A-2483-82 T1. Rendered by Judges Herman D. Michels, Sylvia B. Pressler, and Theodore W. Trautwein.
3. Sullivan R: Court in Jersey forbids removing feeding tube from terminally ill. *New York Times*, July 9, 1983.
4. Brennan MK: New Jersey opinion: The right to die is still unclear. *New York Times*, Aug. 28, 1983.
5. Rothberg H: Patients and physicians, life, and death. *Pastoral Psychology* 23:15-26, 1972.
6. Swazey JB: Treatment and nontreatment decisions: In whose best interests? in, *Dilemmas of Dying: Policies and Procedures for Decisions Not to Treat*. G.K. Hall, 1982, pp 95-101.
7. President's Commission for the Study of Ethical Problems in Medicine: Deciding to forego life-sustaining treatment. U.S. Government Printing Office, March 1983.



INDEX TO MAP

1– HARRAH'S MARINA HOTEL CASINO
2 – ST. MORITZ
3 – ARISTOCRAT
4 – WORLD INTERNATIONAL HOTEL/MOTEL
5 – RESORTS INTERNATIONAL HOTEL-CASINO
6 – BARCLAY
7 – LAFAYETTE MOTOR INN
8 – CATALINA
9 – BARBIZON
10 – CAROLINA CREST
11 – BURGUNDY
12 – TRINIDAD
13 – FIESTA
14 – ENVOY
15 – ACAPULCO
16 – VILLAGE
17 – JEFFERSON
18 – SORRENTO
19 – CONTINENTAL
20 – BALA
21 – MIDTOWN
22 – SANDS HOTEL-CASINO
23 – CLARIDGE HOTEL CASINO
24 – BEST WESTERN INN
25 – EASTBOURNE
26 – MT. ROYAL
27 – BALLY'S PARK PLACE HOTEL-CASINO
28 – CAESARS BOARDWALK REGENCY HOTEL-CA
29 – HARRAH'S BOARDWALK HOTEL
30 – PLAYBOY HOTEL-CASINO
31 – ASCOT
32 – ELDORADO
33 – TROPICANA HOTEL-CASINO
34 – DUNES
35 – DEAUVILLE HOTEL/MOTOR INN
36 – ALGIERS
37 – CASTLE ROC
38 – BARONET
39 – INTERNATIONAL
40 – FLAMINGO
41 – EL GRECO
42 – GOLDEN NUGGET HOTEL-CASINO
43 – LINCOLN BEACH

Housing Application

218th ANNUAL MEETING
THE MEDICAL SOCIETY OF NEW JERSEY

MAY 3-6, 1984

	Single	Twin	Suites
Resorts International (headquarters hotel)	$80.00	$80.00	$171/$250
Harrah's Marina Hotel Casino	$75.00	$75.00	
World International Hotel/Motel	$58.00	$58.00	
Lafayette Motor Inn	$58.00	$58.00	

Rates subject to 12% state and local taxes; tax subject to change.

All hotel reservations for the 218th Annual Meeting of MSNJ will be handled by the Atlantic City Convention Bureau. Please send your housing application with your 1st, 2nd, and 3rd choices directly to the Bureau, 16 Central Pier, Atlantic City, NJ 08401. All Delegates and Members are urged to make their hotel reservations early. Blocks of rooms will be available at Resorts International (headquarters hotel), Lafayette Motor Inn, World International Hotel/Motel, and Harrah's Marina Hotel Casino. The cut-off date for reservations will be April 6, 1984. Reservations cannot be guaranteed after this date. No Saturday arrivals please. All registrants will be charged for three nights: Thursday, Friday, and Saturday, May 3, 4, and 5, 1984.

MAIL THIS APPLICATION DIRECTLY TO THE ATLANTIC CITY CONVENTION BUREAU
16 Central Pier
Atlantic City, NJ 08401

Please list 1st, 2nd, and 3rd choices; confirmation will come directly from hotel.

1st Choice _____ 2nd Choice _____

3rd Choice _____

Accommodations desired: ☐ Single ☐ Twin ☐ Suite Parlor & 1 Bedroom
☐ Suite Parlor & 2 Bedrooms

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

Will arrive _____ (date) Time _____ Will depart _____ (date) Time _____

☐ Check if Official Delegate _____ County _____

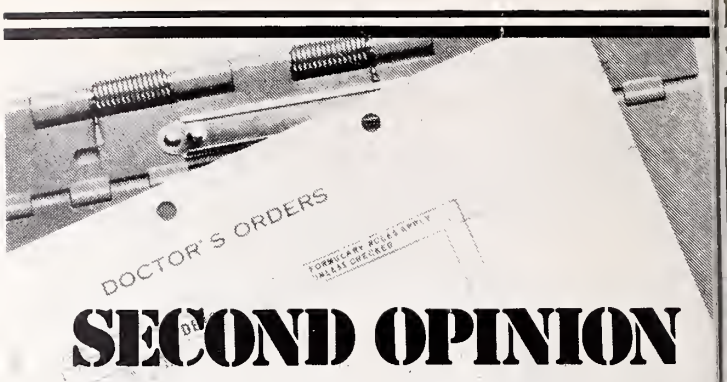
NEW YORK FERTILITY RESEARCH FOUNDATION, INC.

For the Investigation of
Problems of Human Infertility

The Foundation provides a complete diagnostic and consultation service for infertile couples. Investigations are conducted by well-known specialists in conjunction with consultants in the various fields of medicine related to infertility.

The Foundation is supported by an in-house modern laboratory equipped to do most tests required for diagnosis and treatment. Literature on request.

1430 Second Avenue, Suite 103
New York, N.Y. 10021
Phone: (212) 744-5500



SECOND OPINION

Leasing's not for you?

Compare these figures (based on a $20,000 vehicle)

DUE 1ST DAY	PURCHASE	LEASE*
6% sales tax	$1200	$25/mo.
down payment	4000	none
monthly payment	554	410
total due:	**$5754**	**$435**

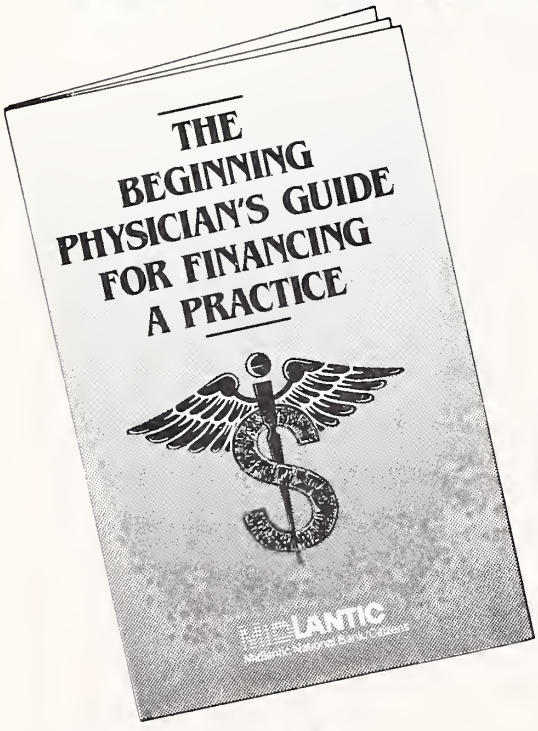
So by leasing, you've got $5319 savings on your initial outlay, plus $119 a month, to invest any way you'd like! And insurance is available to qualified N.J. motorists for as little as $480 a year. Call for similar savings on ANY make or model, foreign or domestic. *36-mo/closed-end

value lease inc

Evenings and weekends, call (201) 530-4088

91 Monmouth St., Red Bank, N.J. 07701 (201) 530-128

Starting A Practice?...Already In Practice? Here's The Practical Guide You Need...FREE!



This booklet will assist you in developing and executing a strategic business plan that will enable you to secure the financing required to build a successful practice.

Written by David J. Shuffler, Vice President of Midlantic National Bank/Citizens and a specialist in medical practice financing, this new guide will prove invaluable.

For your free copy, call David Shuffler now at **201-894-5025** or mail the coupon below.

MIDLANTIC
Midlantic National Bank/Citizens
Offices Throughout Eastern Bergen County. Member FDIC.

Mail To: David J. Shuffler, Vice President
Midlantic National Bank/Citizens
1 Engle Street, Englewood, NJ 07631

Please send me my free copy of **The Beginning Physician's Guide for Financing a Practice.**

NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
PHONE _____
☐ RESIDENT ☐ IN PRACTICE
SPECIALTY _____

DOCTORS' NOTEBOOK

Trustees' Minutes; President's Column; UMDNJ Notes; MSNJ Auxiliary; AMNJ Report; Physicians Seeking Location in New Jersey

Trustees' Minutes January 15, 1984

A regular meeting of the Board of Trustees was held on Sunday, January 15, 1984, at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

Report of the President . . .
Physician Reimbursement Under DRG . . . Noted that if a plan to reimburse physician services under DRG is proposed, MSNJ would take aggressive steps to oppose the project. Noted that this discussion was in reference to the situation at Shore Memorial Hospital and that Mr. Maressa will pursue clarification of the issue.

Report of Executive Director . . .
(1) MSNJ Paid Membership . . . Noted that as of December 31, 1983, there were 7,527 dues-paid members.
(2) AMA Delegation Allocation . . . Noted that MSNJ is awaiting official notification as to the number of New Jersey physicians recorded as AMA members that will affect the AMA delegate allocation for 1984.
(3) DRG Waivers . . . Noted that while the implementation of TEFRA parts A and B billing have been suspended, it is anticipated that TEFRA requirements will be enforced in New Jersey by January 1985, and all hospital-based physicians should be prepared for that eventuality.
(4) Corporate Practice of Medicine . . . Noted that for-profit corporations that are not professional service corporations may not engage in the practice of medicine or employ individuals to practice medicine (with the exception of hospitals) according to a recently rendered opinion by Deputy Attorney General Goltz.
(5) MSNJ Financial Statements . . . Approved the financial statements for the period ending December 31, 1983.
(6) Annual Meeting . . . Empowered the Committee on Annual Meeting to move the Annual Meeting from Resorts International Casino-Hotel if Resorts International does not abide by the signed contract. Note: Resorts International Casino-Hotel informed MSNJ that because they are in the process of renovation, they cannot provide all the room accommodations and hospitality suites as committed; Resorts International was informed that their amended contract was unacceptable and MSNJ is awaiting a response.

NJ Hospital Association . . .
Health Care Costs . . . Referred to the Council on Public Relations the issue of dealing with the high costs of health care, prompted by an article in the *New England Journal of Medicine* entitled, "Rationing Hospital Care: Lessons from Britain."

Council on Mental Health . . .
(1) Prescriptions for Controlled Substances—Manner of Issuance of Prescriptions . . . Approved the following recommendation:

> That the Board of Trustees advises the Department of Health that the 30-day limitation, after the date issued, for filling prescriptions for controlled substances be expanded to include all drugs.

(2) Quality of Patient Care at State Psychiatric Institutions and Community Mental Health Centers in New Jersey . . . Approved the following recommendation:

> That the Board of Trustees appoints an ad hoc committee, with equal representation from MSNJ and the New Jersey Psychiatric Association, to investigate patient care and management in state psychiatric institutions and community mental health centers in New Jersey.

Council on Public Health . . .
Report of the Special Committee on Cancer Control . . .
(1) Oncology Society of New Jersey. . . Referred back to the Special Committee on Cancer Control for further information the following recommendation:

> That physicians in the state who are involved in tumor work be identified and urged to join the Oncology Society of New Jersey.

(2) Establishment of a Cancer Control Coordinating Council . . . Approved the following recommendation:

> That the Medical Society of New Jersey approves the establishment of a Cancer Control Coordinating Council.

Old Business . . .
(1) Urgi-Centers . . . Noted that when urgi-centers are opened in New Jersey, law requires licensure and a certificate of need, except when owned and operated by physicians in their private practice.
(2) New Medical Staff Standards . . . Noted that the JCAH's Board of Commissioners approved rewritten "medical staff standards:"

The new "Medical Staff" chapter allows hospitals either to retain or modify the existing composition of their medical staff. Under the new standards, there will be a single organized medical staff that includes licensed physicians. In addition, at the option of the hospital, the staff may include other licensed individuals permitted by law and the hospital to provide patient care services independently (without supervision or direction). The JCAH has not changed its posture on the appropriateness of having dentists as members of hospital staffs. The intent of the new standards is to indicate that the hospital may broaden its medical staff if such action seems appropriate. Peer recommen-

dations should be considered when granting medical staff membership.

The new chapter states that a majority of the medical staff executive committee must be physician members of the medical staff. The executive committee is responsible for making recommendations to the governing body concerning at least: the structure of the medical staff, mechanisms for reviewing credentials and delineating clinical privileges, membership on the medical staff, clinical privileges for eligible individuals, medical staff quality assurance activities, mechanisms for terminating medical staff membership, and fair hearing procedures.

Clinical privileges are required for all members of the medical staff and also for those who are not members of the medical staff, but who provide patient care services independently. Peer recommendations should be considered when clinical privileges are being granted. All practitioners with privileges must comply with the bylaws, rules, regulations, and policies of the medical staff and have the quality of their care reviewed through the hospital's quality assurance program.

The granting of admitting privileges must be in accordance with state law and criteria developed by the medical staff from standards of medical care. The new "Medical Staff" chapter limits admitting privileges to members of the medical staff. The general medical condition of a patient is the responsibility of a qualified physician member of the medical staff. When nonphysician medical staff members are granted the privilege to admit, their patients must undergo a prompt medical evaluation by a qualified physician. This requirement does not apply to qualified oral surgeons who have been granted the clinical privilege to perform a history and physical examination for patients without medical problems.

In the new "Medical Staff" chapter, responsibility for monitoring and evaluating the quality and appropriateness of patient care and the clinical performance of all individuals with clinical privileges is retained by the medical staff. The standards require that important problems in patient care be identified and resolved and that opportunities to improve care be addressed. The *Accreditation Manual for Hospitals* specifically addresses medical staff monitoring activities in medical departments/services, surgical case review, pharmacy and therapeutics review, medical records review, blood usage review, and antibiotic review.

New Business . . .

(1) Proposed New Rule on Advertising and Solicitation Practices—N.J.A.C. 13:35-6.10 . . . Sent a letter to the State Board of Medical Examiners noting MSNJ's comments on the following paragraphs:

> Paragraph (h) would appear to present an unwieldy format in requiring that all the principals, partners, or officers must be identified, especially when there are three or more licensees in a given practice. Under paragraph (i), the issue of joint and severe liability, however, should not be applicable unless all principals, partners, or officers have contributed to the controlling vote.

(2) AMA National Conference on the Impaired Physician . . . Noted that the 6th AMA National Conference on the Impaired Physician is to be held on September 5-8, 1984, at the Meadowlands Hilton in Secaucus.

(3) JEMPAC Meeting . . . Noted that William E. Ryan, M.D., Chairman of JEMPAC, invited Board members to attend the special JEMPAC Board of Directors meeting on January 26, 1984, when Thomas R. Berglund, M.D., Secretary of AMPAC, will be the guest speaker.

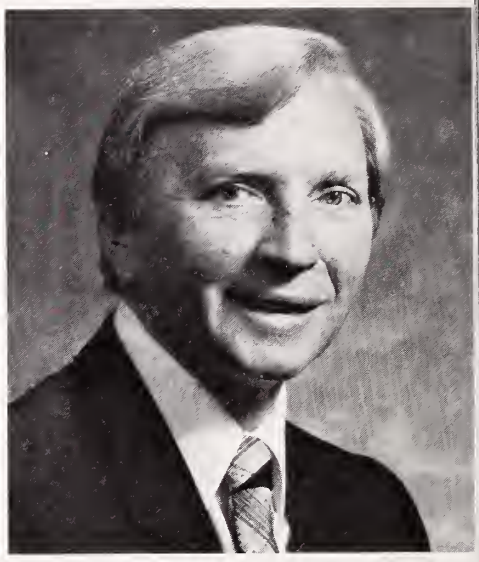
President's Column

Alexander D. Kovacs, M.D.

There are two physicians for each one licensed to practice medicine. There is you and the public perception of you. The "other doctor" to a large extent is a media creation. The public tends to believe he/she is the real you.

Depending upon whether they watch "General Hospital" or "St. Elsewhere," your electronic image is that of a young (usually), good-looking (always), lecherous (most of the time), well-heeled (absolutely) hero (villain). On one hand, your real-life patients get an exaggerated idea of your virtues and talents; on the other hand, they get an exaggerated idea of your venality and incompetence, to say nothing of your sexual prowess.

Your media image performs incredible feats of diagnosis and dramatic "edge-of-the-cliff" surgery—your cures are nothing short of miraculous. Your patients walk into your office looking for a combination of Paul Newman and Albert Schweitzer and find you. There is a certain letdown.



Alexander D. Kovacs, M.D.

At least as bad is the other side of the media coin—the money-hungry incompetent. The patients watching these programs come to your office expecting a combination of Bela Lugosi and Billy the Kid and there you are, Mr. Nice Guy. But they are not buying your act. They are so suspicious that they are off to see a lawyer if you say or do the least little thing that seems odd.

Our profession is served equally poorly by the straight news departments of television, radio, newspapers, and magazines. Premature release of information concerning a new drug or a new procedure can cause a stampede of people demanding a prescription or the latest surgical miracle. If a reporter smells out an article in a professional journal noting potentially adverse reactions to a drug in use, he trumpets the news to the skies and thousands of people throw away their pills often to the detriment of their health.

Whether positive or negative, the end results of sensationalized media are inappropriate expectations, fears of treatment, increased costs,

and unjustified malpractice actions.

How often have you seen news of a large award blazoned across the front page of the paper? Did you ever notice where they hide the news of a reversal or reduction of the same award? On one page, a newspaper will headline a life-prolonging technological breakthrough and on the next bemoan the high cost of medical care.

Complaining about this seems churlish. We are in a high profile profession. My concern is that media distortion creates real health hazards for our patients. Our job, therefore, is to educate them as to the difference between reality and fantasy, between reasonable hope and a fairy tale ending, between scare stories and sober truths.

There is responsible journalism and there is responsible medicine. We cannot do much about the first but we can demonstrate our ability to provide the latter. In the long run, that is the only real refutation we can make.

UMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

Norman H. Edelman, M.D., professor of medicine and physiology and associate dean for research at UMDNJ, Piscataway, has been appointed acting director of the state's proposed major new center for advanced biotechnology, a joint project between UMDNJ and Rutgers, the State University.

Dr. Edelman's appointment was announced in January by both universities after Governor Kean's Commission on Science and Technology strongly endorsed the development of a biotechnology center in Piscataway as part of an extensive package of recommendations aimed at readying New Jersey for the high-technology era. The proposed center will draw on the existing resources of both universities, while fostering cooperative working relationships with other research institutions in the state, including private industry. The center's primary focus will be fundamental research in areas such as genetic engineering, molecular biology, microbiology, biochemistry, and basic pharmacology. The Commission indicated that developing the center would require an estimated capital expenditure of $40 million. The financing will be addressed through a joint bonding initiative involving the state, Rutgers University, and UMDNJ.

Two major grants recently awarded to the department of pediatrics of UMDNJ-Rutgers Medical School, Piscataway, will enable its Division of Child Development to focus on communication disorders in infants and young children.

Michael Lewis, Ph.D., professor of pediatrics, will be director of both the Center for Communication Disorders, which is being established with funding from the Robert Wood Johnson Foundation, and the Language Interaction Intervention Program, which is funded by a grant from the U.S. Department of Education. The four-year, $600,000 Robert Wood Johnson Foundation grant is unique in its focus on children in the 0 to 3 age group and its utilization of an already-existing health network of primary care physicians and communication specialists.

The geographic area to be served encompasses Monmouth, Middlesex, Mercer, and Somerset counties and includes some 59,000 children under 3 years of age, of which at least 2,900 have or are at risk for communication disorders. Three major groups to be targeted are physicians, parents (who will learn from these physicians how to be more aware of possible developmental problems), and communication specialists such as speech pathologists, audiologists, and learning disability consultants. The normal pediatric examination is not oriented toward detection of the more subtle communication disorders. The program would refine current statewide screening procedures. New Jersey law mandates the screening of all newborns for hearing loss and provides for followup examinations and intervention programs for children found to be at risk for communication dysfunction.

The three-year, $400,000 language intervention grant from the U.S. Department of Education will focus on language-delayed children within the existing system of infant stimulation programs in the greater New Brunswick area. These programs are part of a statewide system established by the New Jersey legislature to provide intervention and educational services for handicapped preschool children.

While these centers deal with a great diversity of children who often have multiple developmental problems, Dr. Lewis will focus on communication disorders. Children participating in the program at Rutgers Medical School will work with a speech pathologist while their parents will be taught how to interact in special ways with their children.

MSNJ Auxiliary

Gale Wayman
President

"Gaining the MD—Is the Glamor Gone?" is the title of an article in the January issue of *FACETS*, the AMA Auxiliary magazine. Becoming a physician today has become a tremendous financial burden for would-be physicians and their families. A medical degree translates into an average debt of $40,000 for each graduate of a public medical school and $80,000 for each graduate of a private school. Tuitions are up sharply, to as high as $19,500 a year at schools like Georgetown and George Washington Universities in Washington, D.C.

At the same time, the physician population of the United States has increased, to the point that some physicians today are less willing to support such projects as the Medical Student Loan Fund and AMA-ERF. You are not contributing to your competition; but to better medicine!

AMA-ERF was established in 1951 to help assure quality medical education and to assist research in the nation's medical schools. To date, AMA-ERF has contributed more than $37 million in unrestricted grants directly to the nation's medical schools. Contributions to the fund are accumulated through the year and distributed annually to designated medical schools. Your AMA-ERF donations can be designated to benefit the medical school of your choice, such as your alma mater.

The Foundation also has an Unrestricted Fund which helps support special health and medical pro-

grams and research, or donors can specify research in such fields as neuromuscular diseases, metabolic and endocrine diseases, and arthritis and rheumatism.

When your county auxiliary has fundraising projects for AMA-ERF and Medical Student Loan Fund, will you please give for better medicine in America!

AMNJ Report

Paul J. Hirsch
President

The Academy of Medicine of New Jersey is pleased to announce that Joseph R. Ruggles of Springfield, Ohio, has been appointed to the new position of Associate Director for Continuing Education. Mr. Ruggles presently is Director of Continuing Education at the Community Hospital of Springfield and Clark County, in Springfield. He will be joining the Academy this spring. Mr. Ruggles was selected by the Search Committee from over 100 applicants for the position.

The Academy of Medicine annual Internal Medicine Review Course began on Wednesday, January 11, 1984. It will be held on 19 consecutive Wednesdays, at Overlook Hospital. There was record registration ten days before the program started, and additional registrants were expected.

The First Wednesday program resumed on February 1, 1984. The speaker was Dr. James Todd. His topic was "The Medical-Social-Economic Considerations in the Practice of Medicine in the Future." As is customary, this was a luncheon meeting, held in the headquarters building.

On January 18, 1984, the Academy presented another in its series of Controversies in Medicine. This was a symposium on Controversies in Geriatrics. T. Franklin Williams, M.D., the Director of the National Institute of Aging of the NIH, was the keynote speaker.

On January 17, 1984, the Board of Trustees of the Academy of Medicine selected the recipients for the 1984 Edward J. Ill Award, and the Citizens Award. These names will be included in my report to the MSNJ Board next month.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY—Jan Charles Horrow, M.D., 131 Pond Brook Rd., Chestnut Hill, MA 02167. Pennsylvania 1977. Board certified. Group, academia, HMO. Available.

CARDIOLOGY—Aubrey Orrin Lewis, M.D., 200 Carman Ave., Apt. 21-F, East Meadow, NY 11554. SUNY-Syracuse 1979. Also, general internal medicine. Board certified (IM). Solo, partnership, group, academia (cardiology). Available July 1984.

FAMILY MEDICINE—Jaime F. Lara, M.D., 6045 Palisade Ave., West New York, NJ 07093. Seville (Spain) 1979. Board eligible. Partnership or institutionally based. Available.

GASTROENTEROLOGY—Albert M. Harary, M.D., 2121 N. Bayshore Dr., Apt. 1001, Miami, FL 33137. Columbia 1978. Also, general internal medicine. Board certified (IM). Group, partnership, solo. Available July 1984.

Prakash V. Huded, M.D., 80-15 41 Ave., # 606, Elmhurst, NY 11373. Karnatak (India) 1970. Board certified. Solo, group, partnership. Available.

H.L. Kirschenbaum, M.D., 780 Woolley Ave., Staten Island, NY 10314. New York Med. College 1977. Board eligible. Also, internal medicine. Partnership, group, full-time hospital. Available July 1984.

P. Kothanda Raman, M.D., 9 Lake Ave., Apt. 5A, East Brunswick, NJ 08816. Stanley Medical College (India) 1977. Board eligible (IM). Also internal medicine. Partnership, group, solo. Available July 1984.

INTERNAL MEDICINE—Nicholas Bertini, M.D., 663 Hudson Ave., Albany, NY 12203. SUNY-Buffalo 1980. Board eligible. Group, partnership, solo. Available June 1984.

Harold J. Brown, M.D., 260 Eggerts Rd., Lawrenceville, NJ 08648. UMDNJ 1982. Primary care clinic, HMO, group, partnership. Available July 1985.

Palamadai S. Duraiswami, M.D., 64-A Oneida Ave., Centereach, NY 11720. Stanley Medical College (India) 1976. Board eligible. Available.

Z.U.A. Farooqui, M.D., Plaza Professional Bldg., Bayshore Rd. and Greenwood Ave., Box 238, Villas, NJ 08251. Aurangabad Medical College (India) 1972. Board eligible. Group or partnership. Available.

Elliott Friedman, M.D., 25 Penny La., Baltimore, MD 21209. SUNY-Syracuse 1978. Subspecialty, endocrinology. Board certified (IM); board eligible (M). Group or partnership (both specialties). Available July 1984.

H.L. Kirschenbaum, M.D., 780 Woolley Ave., Staten Island, NY 10314. New York Med. College 1977. Board eligible. Also, gastroenterology. Partnership, group, full-time hospital. Available July 1984.

P. Kothanda Raman, M.D., 9 Lake Ave., Apt. 5A, East Brunswick, NJ 08816. Stanley Medical College (India) 1977. Board eligible. Also, gastroenterology. Partnership, group, solo. Available July 1984.

Andrew L. Saporito, Jr., M.D., 28 Grandview Ave., West Orange, NJ 07052. Guadalajara (Mexico) 1976. Group or partnership. Available.

Steven Wolinsky, M.D., 1404 E. 15 St., Brooklyn, NY 11230. Case Western Reserve 1980. Group or partnership. Available July 1984.

NEPHROLOGY—Arvind Mehta, M.D., 8051 N. Hanover St., Anaheim, CA 92861. Seth G.S. Medical College (India) 1975. Also, internal medicine. Board eligible. Solo, group, partnership. Available.

NEUROLOGY—Elizabeth Kamenar, M.D., 12701 Shaker Blvd., Apt. 410, Cleveland, OH 44120. Ohio State 1975. Board eligible. Group, partnership, academia. Available July 1984.

Robert P. Rubens, M.D., 105 Ward St., Apt. 204, Seattle, WA 98109. UMDNJ-New Jersey Medical School 1980. Board eligible. Available July 1984.

OBSTETRICS/GYNECOLOGY—Alan M. Askinas, M.D., 1309 Carrollton, Apt. 321, Metairie, LA 70005. Illinois 1980. Board eligible. Group, partnership, solo, part academia. Available July 1984.

Wook Chung, M.D., 2212 Watterworth Dr., Kalamazoo, MI 49008. Catholic Medical College (Korea) 1967. Board certified. Solo, group, partnership. Available.

Iris E. Dominy, M.D., 108 Pinegate Circle, Apt. 2, Chapel Hill, NC 27514. Albany 1978. Board eligible. Partnership or group in metropolitan area. Available July 1984.

OPHTHALMOLOGY—Steven R. Davis, M.D., 1000 Lakeview Rd., Clearwater, FL 33516. University of Alabama 1975. Board certified. Solo or association. Available.

Andrew Gewirtz, M.D., 519 Beach 133 St., Belle Harbor, NY 11694. Chicago 1978. Board eligible. Board certified (PD). Group or partnership. Available July 1984.

PATHOLOGY—Mark A. Grathwhol, M.D., 2510 West Tremont Ct., Richmond, VA 23225. NYU 1980. Group. Available July 1984.

Yury Kogan, M.D., 60 Egmont St.,

Brookline, MA 02146. Moscow 1967. Hospital or group. Available July 1984.

PEDIATRICS—Jonathon J. Evans, M.D., 1800 Calvin Ct., #6, Iowa City, IA 52240. Univ. of California-San Diego 1981. Board eligible. Group or HMO. Available July 1984.

Michael J. Foreman, M.D., 2527 Hydraulic Rd., #52, Charlottesville, VA 22901. Hahnemann 1981. Board eligible. Group or partnership. Available July 1984.

PSYCHIATRY—Eric M. Levin, M.D., 43 West 8th St., Media, PA 19063. La Faculté Libre de Medicine (Spain) 1980. Board eligible. Group, institutionally based, CMH outpatient. Available July 1984.

PULMONARY DISEASES—James Kohan, M.D., 19 Highmanor Dr., Henrietta, NY 14467. Virginia 1979. Also, general internal medicine. Board certified (IM). Group, partnership, solo, institutional. Available July 1984.

Dinesh Talati, M.D., 66-02 Grand Central Pkwy., Forest Hills, NY 11375. B.J. Medical College (India) 1974. Board eligible. Solo, group, partnership. Available July 1984.

RADIOLOGY/NUCLEAR MEDICINE—Conrad P. Erlich, M.D., 1243 Beacon St., Apt. 3B, Brookline, MA 02146. Boston 1976. Board certified. Group or partnership. Available July 1984.

Mindy M. Horrow, M.D., 131 Pond Brook Rd., Chestnut Hill, MA 02167. Med College of Pennsylvania 1980. Board eligible. Group, HMO, academia. Available.

RHEUMATOLOGY—Richard Furie, M.D., 435 E. 70th St., Apt. 8-F, New York, NY 10021. Cornell 1979. Also, general internal medicine. Board certified (IM). Group, partnership, solo. Available July 1984.

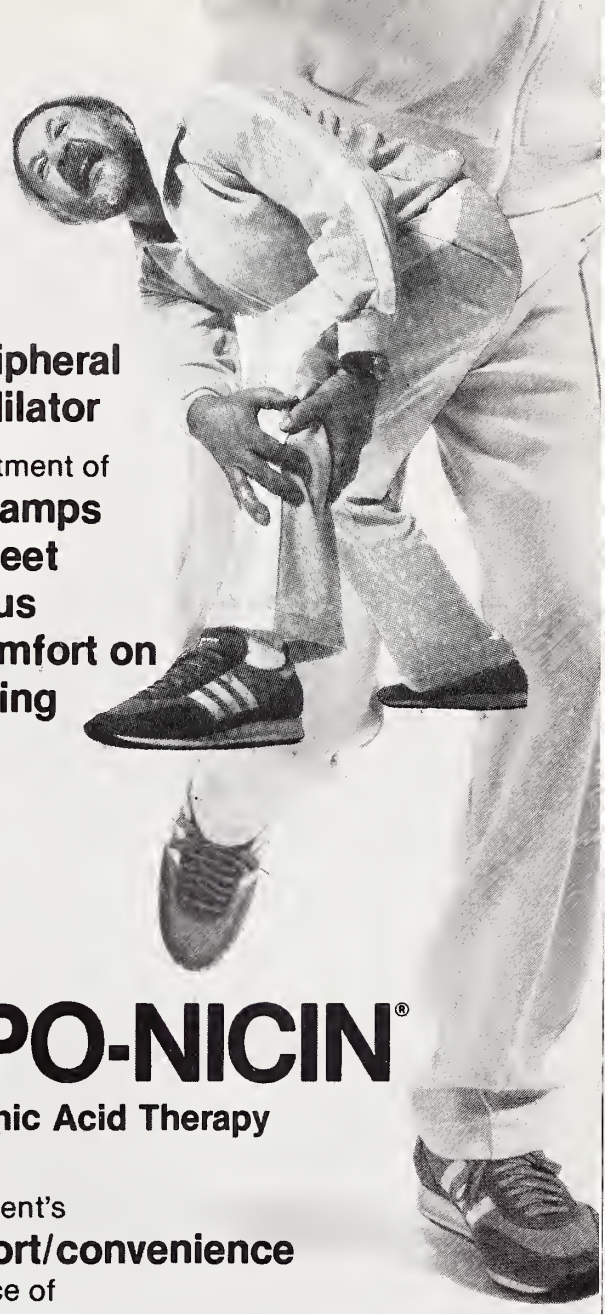
SURGERY, GENERAL—Ramon J. Gomez, M.D., 40-71 Gleane St., Elmhurst, NY 11373. University of the East (Philippines) 1978. Group or hospital-based emergency medicine practice. Available.

F. Andrew Morfesis, M.D., 7545 Rogers Ave., Upper Darby, PA 19082. Penn State (Hershey) 1979. Board eligible. Available July 1984.

SURGERY, ORTHOPEDIC—Jeffrey H. Charen, M.D., 155 Lexington St., Apt. 15, Auburndale, MA 02166. Rochester 1978. Board eligible. Group, partnership, solo (central or northern NJ preferred). Available.

Richard Lebovicz, M.D., 415 Grand St., New York, NY 10002. SUNY-Downstate 1979. Group or partnership. Available July 1984.

UROLOGY—Joseph G. Colonna, M.D., 1234 Van Voorhis Rd., Apt. C-6, Morgantown, WV 26505. Guadalajara (Mexico) 1977. Board eligible. Group or partnership. Available October 1984.



A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release
LIPO-NICIN®/300 mg.

Each time-release capsule contains:
Nicotinic Acid .....300 mg.
Ascorbic Acid.....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2).....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release
LIPO-NICIN®/250 mg.

Each yellow tablet contains:
Nicotinic Acid .....250 mg.
Niacinamide.....75 mg.
Ascorbic Acid.....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2).....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide.....75 mg.
Ascorbic Acid.....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2).....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN **THE BROWN PHARMACEUTICAL CO., INC.**
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

THE ACADEMY OF MEDICINE OF NEW JERSEY—
ORTHOPAEDIC SECTION
THE NEW JERSEY ORTHOPAEDIC SOCIETY
UMDNJ-N.J. MEDICAL SCHOOL—ORTHOPAEDIC DIVISION
ST. JOSEPH'S HOSPITAL AND MEDICAL CENTER—
ORTHOPAEDIC DEPARTMENT
present the

NINTH ANNUAL
N.J. ORTHOPAEDIC SYMPOSIUM

on
Saturday, April 7, 1984
8:00 A.M.-4:00 P.M.
at
UMDNJ-RUTGERS MEDICAL SCHOOL
Piscataway, NJ

The program will include presentations by nationally prominent speakers on long term results of total condylar knee arthroplasty; revision total hip surgery; the girdlestone operation revisited; complications in the treatment of congenital hip disorders under walking age; treatment of painful hip in the young adult; early diagnosis of avascular necrosis of the femoral head and some approaches to treatment; posterior syndromes of the ankle in classical ballet dancers; as well as abstract presentations by New Jersey Orthopaedists.

For further information, please contact:

The Academy of Medicine of New Jersey
Founded 1911

MS. LINDA BARTOLO
The Academy of Medicine of New Jersey
Two Princess Road
Lawrenceville, NJ 08648
(609) 896-1717

THE ACADEMY OF MEDICINE OF NEW JERSEY
in cooperation with
NEWARK BETH ISRAEL MEDICAL CENTER
presents a symposium on

"NEONATAL ULTRASOUND"

on
Saturday, April 14, 1984
at
NEWARK BETH ISRAEL MEDICAL CENTER
201 Lyons Ave.
Newark, N.J.

The program will include presentations by nationally prominent speakers on ultrasound—principles and safety; early pregnancy; intra and extra uterine; placental growth and grading: fetal echocardiography; fetal anatomic abnormalities; neonatal intracranial anatomy and hemorrhage; pregnancy dating and I.U.C.R.; and routine use of ultrasound—yes or no. The program is designed for pediatricians, gynecologists, radiologists, primary care physicians, and other interested professionals.

For further information, please contact:

The Academy of Medicine of New Jersey
Founded 1911

EXECUTIVE OFFICES
The Academy of Medicine of New Jersey
Two Princess Road
Lawrenceville, NJ 08648
(609) 896-1717

LIKOFF CARDIOVASCULAR INSTITUTE
of Hahnemann Medical College & Hospital
230 N. Broad Street, Philadelphia, Pennsylvania 19102 (215) 448-8063

CARDIOLOGY UPDATE. . .

IS DESIGNED FOR THE PHYSICIAN AND PROVIDES AN INTENSIVE SURVEY OF THE CURRENT STATUS OF CLINICAL CARDIOLOGY. . .

WEDNESDAY, APRIL 4, 1984
PERIPHERAL VASCULAR DISEASE
MODERATOR: ABDULMASSIH S. ISKANDRIAN, M.D.

3:00	CASE PRESENTATION	*Daniel Mason, M.D.*
3:30	DIAGNOSIS AND MANGEMENT OF DISSECTING ANEURYSM	*Harold Kay, M.D.*
4:00	ABDOMINAL AORTIC ANEURYSM: DIAGNOSIS AND INDICATIONS FOR SURGERY	*Sheldon R. Bender, M.D.*
4:30	THE ASYMPTOMATIC CAROTID BRUIT	*Joseph R. Carver, M.D.*
5:00	PERIPHERAL VASCULAR DISEASE: DIAGNOSIS AND MANAGEMENT	*David Naide, M.D.*
5:30	PANEL DISCUSSION	

LECTURE HALL "A"—2nd floor New College Building, Hahnemann University
15th and Vine Streets, Philadelphia, PA

• NO REGISTRATION FEE • NO ADVANCE REGISTRATION REQUIRED •
• CME CATEGORY I CREDITS CERTIFIED •
WINE & CHEESE SERVED FOLLOWING CONFERENCE

CME CALENDAR

The following is a list of continuing medical education courses for the next two months. Contact the sponsor for further information.

This list is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the UMDNJ. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

Apr.

16 Pain Therapy
11:30 A.M.- 12:30 P.M.—Columbus Hospital, Newark
(AMNJ)

CARDIOLOGY

Apr.

1 Cardiac Doppler

28 Quantitative Echocardiography

29 Left Ventricular Function by M-Mode, 2D, and Doppler Echocardiography
9 A.M.- 5:30 P.M.—Nassau Inn, Princeton
(Practical Diagnostic Ultrasound Seminars and AMNJ)

17 Management of Unstable Angina
12 noon—St. Mary's Hospital, Orange
(AMNJ)

25 Management of Acute Myocardial Infarction
1-2:30 P.M.—VA Medical Ctr., Lyons
(VA Medical Ctr. and AMNJ)

May

2 Recent Advances in Echocardiology
1-2:30 P.M.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

2 Cardiovascular Evaluation and Treatment of Patients with Recurrent Syncope
9-11 P.M.—Middlesex General Hospital, New Brunswick
(Middlesex General-University Hospital and AMNJ)

5 Advanced Echocardiography

6 9 A.M.- 5 P.M.—Center for Health Affairs, Princeton
(The National Foundation for Non-invasive Diagnostics and AMNJ)

19 Prosthetic Cardiac Valves

20 Summary of M-Mode, 2D, and Doppler Echo Features for Acquired and Congenital Cardiac Lesions
9 A.M.- 5:30 P.M.—Nassau Inn, Princeton
(Practical Diagnostic Ultrasound Seminars and AMNJ)

MEDICINE

Apr.

2 Laser Treatment—GI
1:30 P.M.—Columbus Hospital, Newark
(AMNJ)

4 Medical Grand Rounds
11:30 A.M.—VA Medical Center, East Orange
(Endocrinology Section, AMNJ)

4 Common Foot Problems

18 Acne
1:30-2:30 P.M.—Rutgers Community Health Plan, 57 U.S. Hwy #1, New Brunswick
(Rutgers Community Health Plan and AMNJ)

4 Alcoholism
1:30 P.M.—Essex County Hospital Ctr., Cedar Grove
(AMNJ)

4 Antibiotic Nephrotoxicity
1-2:30 P.M.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

4 Hypertension in the Elderly

25 Paget's Disease
1-2:30 P.M.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

4 Cutaneous Manifestations of Systemic Diseases

11 Medical Treatment of Gallbladder Disease

18 Osteoporosis and Kidney Stones

25 The Powerful New Role of Monoclonal Antibodies in Medical Diagnosis and Treatment
9-11 A.M.—Middlesex General-University Hospital, New Brunswick
(Middlesex General-University Hospital and AMNJ)

4 Endocrine Conferences

11 3:30-5 P.M.—Rotates between

18 Newark Beth Israel Med. Ctr.,

25 University Hospital, and United Hospitals Medical Ctr., Newark, and VA Medical Center, East Orange
(Endocrinology Section, AMNJ)

5 Medical Grand Rounds
9:30 A.M.—Newark Beth Israel Medical Ctr.
(Endocrinology Section, AMNJ)

5 Psychosocial Care and Unorthodox Cancer Therapies
4-6 P.M.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

6 Medical Grand Rounds
11:30 A.M.—University Hospital, Newark
(Endocrinology Section, AMNJ)

6 Renal Conferences in Nephrology

20 4-5 P.M.—University Hospital, Newark
(Nephrology Society of NJ and Nephrology Section, AMNJ)

12 Nutritional Support of Hospitalized Patients

19 The Conditioning of Athletes
11 A.M.—St. Joseph's Hospital and Medical Center, Paterson
(St. Joseph's Hospital and AMNJ)

13 Controversies in the Management of Otitis Media
8-9:30 A.M.—Overlook Hospital, Summit
(Overlook Hospital and AMNJ)

17 Laser Treatment of Massive Gastrointestinal Hemorrhage
11 A.M.- 12 noon—Greystone Park Psychiatric Hospital
(Greystone Park Psychiatric Hospital and AMNJ)

17 Renal Osteodystrophy
4-5 P.M.—Academic Health Science Ctr., New Brunswick
(UMDNJ-Rutgers Medical School and AMNJ)

18 Substance Abuse and Misuse
8:30 A.M.- 1 P.M.—Medical Society of New Jersey, Lawrenceville
(NJ State Department of Health, MSNJ, and AMNJ)

18 Dermatological Conference
6-9 P.M.—Rutgers Community Health Plan, 57 U.S. Hwy. #1, New Brunswick
(UMDNJ and AMNJ)

19 Perception of Pulmonary Lesions
1:30-5 P.M.—Saint Barnabas Medical Ctr., Livingston
(Saint Barnabas Medical Ctr. and AMNJ)

24 How Scientific Is Modern Medicine?
7:30-8:30 P.M.—Ramada Inn, Exit 135, Garden State Parkway
(Nephrology Section of NJ and AMNJ)

26 Renal Hemodynamics of Hypertension
11 A.M.- 12:30 P.M.—St. Joseph's Hospital, Paterson
(St. Joseph's Hospital and Medical Center and AMNJ)

26 Regional Hospital Meeting
8-10 P.M.—Overlook Hospital, Summit
(NJ Gastroenterological Society and AMNJ)

May

1 Strokes, C.V.A.—Post and Rehab Care
11 A.M.- 12 noon—Greystone Park

The Academy of Medicine of New Jersey
The Medical Society of New Jersey
The N.J. State Department of Health

present a symposium on

"SUBSTANCE ABUSE AND MISUSE"

on
WEDNESDAY, APRIL 18, 1984
9:00 A.M.-1:00 P.M.

at
MSNJ HEADQUARTERS BUILDING
Lawrenceville, N.J.

The program will include presentations by nationally prominent speakers on current concepts in the diagnosis and treatment of substance abuse disorders, update on cocaine abuse and prescription drug abuse as well as other pertinent topics. The program is designed for physicians and all other health care providers who have encountered or do encounter any of these problems in their professional work.

For further information, please contact:

The Academy of Medicine of New Jersey
Founded 1911

EXECUTIVE OFFICES
The Academy of Medicine of New Jersey
Two Princess Road
Lawrenceville, NJ 08648
Phone: (609) 896-1717

NYU

Post-Graduate Medical School

APRIL	
4/3-10/16	Emergency Medicine Board Review (Tuesdays, 4-7 P.M.)
4/26-4/28	Update in Dermatology
MAY	
5/3-5/5	The Medicolegal Autopsy
5/10-5/13	CT of the Spine (Grand Hyatt Hotel)
5/19-5/20	Review of Basic Sciences in Urology
5/19-5/20	Proficiency in Cytopathology
5/19-5/20	Practical Management of Gynecologic Endocrine Disorders and Infertility
JUNE	
6/4-6/6	Obstetrical Ultrasound
6/4	Interventional Radiology and Digital Imaging
6/5-6/9	Computed Tomography Head to Toe with MRI
6/11-6/15	Emergency Medicine
6/23 & 6/24	Chymopapain I & II (2 intensive 1 day sessions)
6/25-6/28	Pediatric and Adolescent Medicine
AUGUST	
8/27-8/31	Radiation Physics and Biology

FOR INFORMATION

NYU Post-Graduate Medical School
550 First Avenue, New York, N.Y. 10016
(212) 340-5295 (24 hr. service)

Update in Occupational Medicine

Jefferson Medical College
Department of Medicine
May 1-3, 1984

18 Hours Category I
AMA Continuing Education Credit

Fee: $125.00 per day or $325.00 for full 3 days

Topics to be included:
Biological Monitoring, Health Promotion
Occupational Pulmonary Diseases and Ergonomics

To obtain a brochure and enrollment form please contact:

Cynthia Papaleo
Department of Medicine
Jefferson Medical College
1025 Walnut Street
Philadelphia, PA 19107
(215) 928-8787

Jefferson Medical College of Thomas Jefferson University

presents

2ND ANNUAL UPDATE IN INTERNAL MEDICINE

May 16-18, 1984
at
The Hershey Philadelphia Hotel

A three day intensive symposium sponsored by the Department of Medicine, Jefferson Medical College, 1025 Walnut Street, Philadelphia, Pennsylvania.

ACME approved: 20 credit hours in Category I
Willis C. Maddrey, M.D. Program Director
John H. Martin, M.D. Associate Director

A registration fee of $375.00 includes course syllabus, continental breakfasts, coffee breaks, luncheons and a reception-dinner.

For information and registration, call the Office of CME at (215) 928-6992.

Psychiatric Hospital
(Greystone Park Psychiatric Hospital and AMNJ)

2 Medical Grand Rounds
11:30 A.M.—VA Medical Center, East Orange
(Endocrinology Section, AMNJ)

2 Nephrotoxicity of Common Drugs
1:30-2:30 P.M.—Essex County Hospital, Cedar Grove
(AMNJ)

2 William P. Burpeau Award Dinner and Memorial Lecture
6:30 P.M.—The Manor, West Orange
(Urology Section, AMNJ)

2 Occupational Medicine for the Primary Physician

30 Cancer Emergencies
1:30-2:30 P.M.—Rutgers Community Health Plan, 57 U.S. Hwy. #1, New Brunswick
(Rutgers Community Health Plan and AMNJ)

2 Endocrine Conferences
9 3:30-5 P.M.—Rotates between
16 Newark Beth Israel Medical Ctr.,
23 University Hospital, Newark, and
30 United Hospitals Medical Ctr., Newark, and VA Medical Ctr., East Orange
(Endocrinology Section, AMNJ)

3 Fever of Unknown Origin in the 1980s

24 Carcinoma of the Colon
11 A.M.—St. Joseph's Hospital, Paterson
(St. Joseph's Hospital and Medical Center and AMNJ)

3 Recurrent Abdominal Pain
9 A.M.—Freehold Area Hospital
(AMNJ)

3 Medical Grand Rounds
9:30 A.M.—Newark Beth Israel Medical Ctr.
(Endocrinology Section, AMNJ)

3 Chemotherapy
4-6 P.M.—Institute for Medical Research, Copewood Street, Camden
(Institute for Medical Research and AMNJ)

3- 218th Annual Meeting
6 Resorts International, Atlantic City
(Medical Society of New Jersey and AMNJ)

4 Medical Grand Rounds
11:30 A.M.—University Hospital, Newark
(Endocrinology Section, AMNJ)

4 Renal Conferences in Nephrology
18 4-5 P.M.—UMDNJ-University Hospital, Newark
(Nephrology Society of NJ and Nephrology Section, AMA)

8 Principles of Hyperalimentation in Trauma Patients
7-9 A.M.—Hackensack Medical Center
(Hackensack Medical Center and AMNJ)

15 Newer Concepts in CPR
12:00 noon—St. Mary's Hospital, Orange
(AMNJ)

15 Drugs and Water Metabolism
4-5 P.M.—Academic Health Science Ctr., Rm. 393, New Brunswick
(UMDNJ and AMNJ)

15 Renal Hormone Resistant States
7-8 P.M.—Ramada Inn, Clark
(Nephrology Society of NJ and AMNJ)

15 AIDS/Herpes

29 Clinical Treatment of Headache
11 A.M.- 12 noon—Greystone Park Psychiatric Hospital
(Greystone Park Psychiatric Hospital and AMNJ)

16 Drugs, Alcohol, and Pregnant Women
8:30 A.M.- 3:15 P.M.—Monmouth Medical Ctr., Long Branch
(Div. of Alcoholism, NJ State Dept. of Health and AMNJ)

16 Dermatological Conferences
6-9 P.M.—Rutgers Community Health Plan, 57 U.S. Hwy. #1, New Brunswick
(UMDNJ-Rutgers Medical School and AMNJ)

16 Modern Medical Genetics

23 Diseases of Mucous Membrane
10:30-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

17 Newer Concepts in Sarcoidosis
5-6:30 P.M.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

Clinical Concerns in Hemodialysis Patients

18 8:15 A.M.- 5 P.M.
19 8 A.M.- 1 P.M.—New York Hilton Hotel, New York City
(Nephrology Society of NJ and AMNJ)

30 Gastrointestinal Bleeding
10:30 A.M.- 12 noon—St. Mary's Hospital, Passaic
(AMNJ)

30 Hepatic Metabolic Complications of Alcoholism
1-2:30 P.M.—VA Medical Ctr., Lyons Bldg. 93
(VA Medical Ctr. and AMNJ)

31 How To Live To Be 100
11 A.M.—St. Joseph's Hospital, Paterson
(St. Joseph's Hospital and Medical Center and AMNJ)

NEUROLOGY/PSYCHIATRY

Apr.

2 Identity Disorder Versus Borderline Personality
8:15-10:30 P.M.— 5 Fairfield St., Montclair
(Essex Psychiatric Seminar and AMNJ)

5 Behavior Medicine and Biofeedback

12 Treatment Issues of the Depressed Woman

19 Cross-Cultural Psychiatry
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

6 Psychiatric Lecture Series
13 1:30-5 P.M.—Trenton Psychiatric
27 Hospital
(Trenton Psychiatric Hospital and AMNJ)

9- Developmental-Behavioral
13 Disorders: Update 1984
Glenpointe Hotel, Teaneck
(Hackensack Medical Center and AMNJ)

11 The Sleepless Patient
9:15 A.M.- 4:30 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

11 Update in Psychosomatic Medicine
2-5 P.M., 7-9 P.M.—Stony Hill Inn, Hackensack
(North Jersey Psychiatric Society and AMNJ)

16 Principles of Child Psychotherapy
8:30-10:30 P.M.— 301 Broad Ave., Englewood
(NJ Psychoanalytic Society and AMNJ)

18 Group Therapy
25 2-3 P.M.—Ancora Psychiatric Hospital, Hammonton
(Ancora Psychiatric Hospital and AMNJ)

19 Controversies and Pitfalls in Modern Sex Therapy
5-6:30 P.M.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

May

2 Epilepsy-Classification and New Treatment
10:30 A.M.- 12 noon—St. Mary's Hospital, Passaic
(AMNJ)

2 Group Therapy
16 2-3 P.M.—Ancora Psychiatric
30 Hospital
(Ancora Psychiatric Hospital and AMNJ)

3 The Hypochondriacal Patient

10 Adolescents and Families with Drug and Alcohol Problems

17 Medication Treatment of Phobias

31 ECT: Sine *v* Pulse Wave and Other New Developments
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

4 Psychiatric Lecture Series
11 1:30-5 P.M.—Trenton Psychiatric Hospital
18 *(Trenton Psychiatric Hospital and*
25 *AMNJ)*

7 Effect of Porno Pictures on Sexual Compulsion of a 5-Year-Old Child
8:15-10:30 P.M.— 9 Marquette Road, Montclair
(Essex Psychiatric Seminar and AMNJ)

7 Psychotherapies
14 1-3 P.M.—Ancora Psychiatric
21 Hospital
28 *(Ancora Psychiatric Hospital and AMNJ)*

9 Convulsive Seizures
1-2:30 P.M.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

ACUPUNCTURE IN CLINICAL PRACTICE

N.Y. State Boards of Medicine & Dentistry 25-hour accredited seminar and workshop on the latest theories & techniques of manual and electro-acupuncture, applicable toward the 200-hour requirement for certification, will be given for licensed clinicians (with or without prior training) during the weekend of March 23-25, 1984 and again the weekend of May 25-27, 1984 at the Barbizon Plaza Hotel, New York City. Co-sponsored by the International College of Acupuncture & Electro-Therapeutics, its official journal (published by Pergamon Press) the Heart Disease Research Foundation and the Neuroscience Dept. of Long Island College Hospital, Pharmacology Dept. of The Chicago Medical School. Also eligible for AMA/CME credit. For information, contact Y. Omura, M.D., ScD., 800 Riverside Drive (8-1), NYC 10032. Tel: (212) 781-6262 or (212) WA8-0658, or Saul Heller, M.D., Tel: (212) 838-7514.

TAX PREPARATION AND PLANNING

- Individual, Partnership, Corporate, Business, Estate Services
- Expert Services
- Federal, Any State, Foreign Taxes of any type
- All Year Service
- Audit Representation
- Tax Planning and Reduction
- In Home or In Office Service

H. Michael Zukowski
(201) 945-8443

Want to expand your practice?
we are
SPECIALISTS
in
PUBLIC RELATIONS
FOR THE MEDICAL PROFESSION
for a confidential interview call—
(201) 531-7080



phyllis kessel associates
780 West Park Avenue, Oakhurst, N.J. 07755

Doctors: Write your own prescription to cure insurance pains . . .

℞ Prescription

Name MSNJ Member

MSNJ Group
Blue Cross/Blue Shield Major Medical and Dental Insurance

that provides:

- **Flexible plans**
- **Comprehensive benefits**
- **Low, competitive rates**
- **Centralized Administration**

Designed and Administered by
DONALD F. SMITH & ASSOCIATES

℞ Prescription

Name _____

Address _____

Phone _____

Please send more information on the MSNJ

- ☐ Blue Cross/Blue Shield Program
- ☐ Major Medical Program
- ☐ Group Dental Program

Return to:
Donald F. Smith & Associates
One Airport Place, Route 206 North
P.O. Box 2197,
Princeton, New Jersey 08540
(609) 924-8700, (201) 622-6046

15 **Adolescent Health and Illness**
16 9 A.M.- 4:30 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

17 **Aspects of Manic-Depressive Illness**
8-10 P.M.—Hackensack Medical Ctr.
(NJ Psychoanalytic Society and AMNJ)

21 **Principles of Child Psychotherapy**
8:30-10:30 P.M.— 301 Broad St., Englewood
(NJ Psychoanalytic Society and AMNJ)

22 **Family Therapies**
1-3 P.M.—Ancora Psychiatric Hospital
(Ancora Psychiatric Hospital and AMNJ)

OBSTETRICS/GYNECOLOGY

Apr.

1 **Contraception Today: Improving the Results, Reducing the Concerns**
9 A.M.-12 noon—Princeton Scanticon Conference Ctr., Princeton
(UMDNJ and AMNJ)

PATHOLOGY

Apr.

11 **Pathology Grand Rounds**
10:30 A.M.-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

12 **Radio-labeled Antibodies for Cancer Detection and Therapy**
4-6 P.M.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

May

9 **Pathology Grand Rounds**
10:30-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

PEDIATRICS

Apr.

5 **Hematonia and Proteinuria in Children**
9 A.M.—Freehold Area Hospital
(AMNJ)

16 **Pediatric Lecture Series**
12 noon-1 P.M.—The Mountainside Hospital, Montclair
(The Mountainside Hospital and AMNJ)

25 **Pediatric Allergy**
10:30 A.M.-12 noon—St. Mary's Hosptial, Passaic
(St. Mary's Hospital and AMNJ)

May

10 **Pediatric Malignant Diseases**
4-6 P.M.—Institute for Medical Research, Copewood Street, Camden
(Institute for Medical Research and AMNJ)

18 **Changing Concepts in the Treatment of Seizures**
8-9:30 A.M.—Overlook Hospital, Summit
(Overlook Hospital and AMNJ)

21 **Outcome of High-Risk Infants**
12 noon-1 P.M.—The Mountainside Hospital, Montclair
(The Mountainside Hospital and AMNJ)

RADIOLOGY

Apr.

7 **Real-Time, Cross-Sectional**
8 **Sector Scanning**
9 A.M.- 5 P.M.—Center for Health Affairs, Princeton
(The National Foundation for Non-invasive Diagnostics and AMNJ)

12 **Invasive Fetal Therapy**
8:30-9:30 P.M.—Saint Barnabas Medical Ctr.
(New Jersey Institute of Ultrasound in Medicine and AMNJ)

18 **Pathogenesis, Diagnosis, and Management of Type II Diabetes**
1-2:30 P.M.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

19 **Radiology Meeting**
7:30-10 P.M.—Saint Barnabas Medical Ctr., Livingston
(Radiological Society of NJ and Diagnostic Radiology Section, AMNJ)

26 **Radiation Therapy: Current Practice and Future Potential**
4-6 P.M.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

May

16 **Dinner Meeting**
6:30 P.M.—The Manor, West Orange
(Radiotherapy Section, AMNJ)

17 **Combined Meeting**
7:30-10 P.M.—Saint Barnabas Medical Ctr., Livingston
(NJ Institute of Ultrasound, Radiological Society of NJ, and Diagnostic Radiology Section, AMNJ)

24 **Forensic Radiology**
1:30-5 P.M.—Saint Barnabas Medical Ctr., Livingston
(Saint Barnabas Medical Ctr. and AMNJ)

SURGERY

Apr.

4 **In and Out Surgery**
10:30 A.M.- 12 noon—St. Mary's Hospital
(AMNJ)

4 **Surgical Departmental**
11 **Conferences**
18 8:30 A.M.- 10 A.M.—Rutgers Medical
25 School, New Brunswick
(UMDNJ and AMNJ)

10 **Current Approach to Management of Thromboembolism**
7-9 A.M.—Hackensack Medical Center
(Hackensack Medical Center and AMNJ)

May

2 **Surgical Departmental**
9 **Conferences**
16 8:30-10 A.M.—Rutgers Medical
23 School, Medical Education Bldg.,
30 New Brunswick
(UMDNJ and AMNJ)

16 **Common Outpatient Surgical Problems**
1:30-2:30 P.M.—Community Health Plan, New Brunswick
(Rutgers Community Health Plan and AMNJ)

30 **Surgical Nutrition**
1-2:30 P.M.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

SURGICAL SPECIALTIES

Apr.

5 **Vascular Surgical Rounds**
12 4-5 P.M.—Rutgers Medical School,
19 New Brunswick
26 *(UMDNJ and AMNJ)*

6 **Second Annual Meeting—Delaware Valley Vascular Society**
8 Caesars Boardwalk Regency, Atlantic City
(Delaware Valley Vascular Society and UMDNJ)

7 **9th Annual Orthopaedic Symposium**
8 A.M.—UMDNJ-Rutgers Medical School Newark
(AMNJ)

11 **Yag Laser Use In Ophthalmology**
1-2:30 P.M.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

18 **Biliary Tract Surgery**
10:30 A.M.- 12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

26 **Glaucoma: A Compendium of Diseases**
8-10 P.M.—Bergen County Medical Society, Hackensack
(Med. Women's Assoc. and AMNJ)

May

3 **Vascular Surgical Rounds**
10 4-5 P.M.—Rutgers Medical School,
17 Medical Education Bldg., New
24 Brunswick
31 *(UMDNJ and AMNJ)*

MISCELLANEOUS

Apr.

3 **Computers in Medicine**
11 A.M.- 12 noon—Greystone Park Psychiatric Hospital
(Greystone Park Psychiatric Hospital and AMNJ)

May

1 **Computers in Medicine**
7:30 P.M.—Burdette Tomlin Mem. Hosp., Cape May Court House
(AMNJ)

10 **Patient Advocacy Issues Two Years Later**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

A WORD TO THE WHYS

WHY AMA?

The AMA helps maintain high standards in Continuing Medical Education through its participation in the Accreditation Council for Continuing Medical Education (ACCME). The AMA also helps reduce the high cost of CME by offering 28 Video Clinic study courses for CME credit. Upholding CME standards and providing cost-effective CME alternatives: it's one more good reason why you should be a part of the AMA.

WHY AMA? The AMA provides a democratic forum where you, along with your colleagues across the country, can raise and argue issues, reach a consensus and formulate policy. AMA policy is then translated into practical actions on issues that affect you and your practice. Making sure medicine stays active, strong and united: it's one more good reason why you should be a part of the AMA.

WHY AMA? The AMA has taken an important initiative in combating prescription drug abuse. An informal steering committee organized by the AMA has developed a data analysis system that would help states detect sources of prescription drug diversion. Cracking down on prescription drug abuse: it's one more good reason why you should be part of the AMA.

To Join, Contact your county or state medical society or write: Division of Membership, AMA, 535 North Dearborn Street, Chicago, Illinois 60610 or call collect, (312) 751-6196.



Letters to the Editor

Pulmonary Edema Complicating Epiglottitis; Temporary Vocal Cord Paralysis; Total Mastectomy versus Partial Mastectomy and Radiation Therapy; Amyloidosis

Pulmonary Edema Complicating Epiglottitis

November 22, 1983

Dear Doctor Krosnick:

Our attention was drawn to the article by Dr. Blankson (November 1983) on pulmonary edema complicating epiglottitis. We would like to comment that although the complication is interesting from a pathophysiological point of view this should not distract the reader from appreciating the fact that mismanagement of the acute airway problem probably led to the development of the pulmonary edema.

Where the diagnosis of epiglottitis is suspected the only foreign body which should be inserted into the mouth would be a cautiously inserted laryngoscope under controlled anesthetized conditions immediately prior to intubation. The route of intubation following pharyngo-laryngeal inspection should be oral, initially, and only after a satisfactory orotracheal airway has been established should the substitution of a nasotracheal tube be considered.

Having to resort to establishing an airway by emergency tracheotomy would appear to indicate the occurrence of serious hypoxic-obstructive problems, which makes the development of the subsequent complication no surprise. The rapid resolution of the pulmonary edema, we believe, would support this contention.

(signed) W. Eric Scott, M.D., Head
Division of Critical Care Medicine
Cooper Hospital/
Univ. Medical Center

Carolyn Bekes, M.D.
Director, Intensive Care Unit
Cooper Hospital/
Univ. Medical Center

December 9, 1983

Dear Doctor Krosnick:

I have read with much interest the letter of Dr. Scott and Dr. Bekes in reply to my article on pulmonary edema complicating epiglottitis. It is quite pretentious of them to suggest that the pulmonary edema may have been caused by mismanagement! In the first place, I do not know where they got this impression from. In the second place, they are asserting by their claim that the 5 to 6 percent of epiglottitis that develops pulmonary edema is due to mismanagement. They either may not be familiar with the entity I described or have chosen to ignore it since it was first described in 1977. As a matter of fact, some authors have proposed that this type of pulmonary edema is caused by the relief of intrapulmonary pressure by the endotracheal intubation.

The duration of treatment of noncardiac pulmonary edema cannot be taken as proof of the cause of the edema. The short duration of treatment of my patient is no proof of anything, except the elimination of the obstruction and the concomitant hypoxia which together, I believe, may cause the pulmonary edema of airway obstruction.

The patient in my report was not mismanaged and pulmonary edema due to upper airway obstruction exists. I suggest to Dr. Scott and Dr. Bekes that they consult the references to the original article.

(signed) Victor N. Blankson, M.D.

Temporary Vocal Cord Paralysis

December 15, 1983

Dear Doctor Krosnick:

On December 13, 1983, I examined the patient with the temporary vocal cord paralysis (*J Med Soc NJ* 80:841, 1983).

On indirect laryngoscopy, he moves both cords well. I hope this is an adequate reply to Dr. Lawrence J. Pizzo's query, and we thus establish definitely the temporary nature of the left vocal cord paralysis.

(signed) Nicholas J. Demos, M.D.

Total Mastectomy *v* Partial Mastectomy and Radiation Therapy

December 19, 1983

Dear Doctor Krosnick:

It now is without doubt that lumpectomy and irradiation are valuable options for women who have breast cancer. Reports and results confirmed the earlier nonrandomized cases of breast cancer treated by lumpectomy (partial mastectomy) and radiation. Dr. Vera Peter's results regarding her work were outstanding. Pierquin's series was likewise excellent and every physician knows about Veronesi's report on lumpectomy and radiation versus mastectomy. Dr. Hellman's persistence in giving the patients an alternative treatment has paid. Most recently, preliminary results from the National Cancer Institute likewise are very promising.[1] The NCI (National Cancer Institute's randomized trial) to date has collected 120 patients: 60 patients had modified radical mastectomy and 60 patients had lumpectomy and local radiotherapy. Dr. Samuel Broder, Director of the Division of Cancer Treatments Clinical Oncology Program, stated that "data collected to date (although too early for a final conclusion) suggest that radiotherapy will prove to be equivalent to mastectomy in terms of disease-free survival with the added feature of excellent cosmetic results."

All practicing physicians should know that, at present, mastectomy does not have to be done to be able to achieve local control. Surgeons in particular should have an open mind regarding the initial management of early breast cancer. They should realize that local control could be achieved by doing less than modified radical mastectomy. Surgeons have to know that microscopic disease can be eradicated by radiation given the proper dose.

The advantage of lumpectomy and radiation over mastectomy obviously is cosmetic. We now know that lumpectomy and radiation are not better than mastectomy nor the latter better than the former. Surgeons should do their best to follow the NSBP Protocol 06 recommendation for the direction of the incision used for tumorectomy.[2] This Protocol also recommends a separate incision for the axillary surgery. If one incision is done for excision of an upper outer quadrant mass, this will result in lateral deviation of the breast. Likewise, radiation oncologists have to pay meticulous attention to the treatment plan and technique for radiating an intact breast. If not, we might pass up a very good opportunity to give these patients a very viable alternative.

(signed) Roy C. Cabrera, M.D.
Louis E. Schwartz, M.D.

REFERENCES

1. The Clinical Cancer Letter, October 1983.
2. Bedwinek JM: Treatment of stage I and II adenocarcinoma of the breast by tumor excision and irradiation.

Amyloidosis

December 20, 1983

Dear Doctor Krosnick:

I read with great interest in the December issue the article on amyloidosis by Drs. Zauber and Wallen. It is an excellent review of the complex and increasingly relevant disease group. The summary of the chemical nature of the beta fibrilloses especially is enlightening.

At one point, the authors state: "Amyloid formation not only requires a protein with intrinsic amyloidogenic properties, but probably involves modification of a precursor protein." The statement is somewhat confusing, as it describes two different types of amyloidosis. In primary amyloid, it is an amyloidogenic protein—the variable portion of light chain—whereas in the secondary form, modification of a normal precursor, SAA, to amyloidogenic AA, that leads to amyloid formation. In addition, prealbumin, a normal circulating protein, appears to participate in amyloidogenesis in the increasingly recognized heredofamilial forms of the disease. Senile amyloidosis, especially cardiac and cerebral, remain poorly understood. The nature and pathogenesis of amyloidosis continue to be the subject of intense research effort.

(signed) John Varga, M.D.
Boston University Medical Center

Basic and Clinical Endocrinology; Emergency Medicine; Fundamentals of Family Medicine; Health and Human Values; Male Reproduction and Fertility; Medicine for the Practicing Physician; Practical Infectious Diseases

Basic and Clinical Endocrinology

F.S. Greenspan and P.H. Forsham. Lange Medical Publications, Los Altos, CA, 1983. Pp. 646. ($25)

In this book, we find a selected discussion presented by many contributing authors. The text covers a wide panorama of basic endocrinology, laced with pathophysiologic, clinical diagnostic, and therapeutic information. The reader will uncover information that is well known as well as information that is considered investigational; both with up-to-date commentary. Besides the various glands examined individually, we find such topics as pediatric, pubertal, and pregnancy endocrinology; gut regulatory peptides; lipoprotein metabolism; obesity; ectopic hormone production; hormones and cancer; multiple endocrine gland syndromes; and low T3 and low T4 syndrome.

The information is well presented and the text is nicely written. A few editing errors, such as in the thyroid section (figure 7-3, page 131), may be confusing to the medical student. The wealth of pertinent information is valuable to the beginner and the practicing endocrinologist. Adequate references are quoted following each chapter for those interested in further specific discussion and investigation. The figures, tables, and graphs are helpful for understanding and formulation of diagnostic and therapeutic methodology—the backbone of clinical endocrinology. I congratulate the authors on their presentation and organization of the voluminous material and look forward to the promised second edition in two years.

Mark M. Singer, M.D.

Emergency Medicine

Harold L. May, M.D., (ed). New York, NY, John Wiley & Sons, 1984. Pp. 1,062. Illustrated.

This hard-covered text of over 1,000 pages appears to have been developed for teaching purposes in a medical school or emergency medicine residency program, or as a reference book in a hospital library.

The text is written in great detail and includes postemergency treatment. It is well-illustrated wherever necessary. At the end of each chapter there are many bibliographic listings for suggested readings in the various subjects in each chapter.

There are 79 contributors, of which 86 percent are medical school instructors and the balance of the contributors write about specific specialties. There are subjects discussed that go beyond the emergency treatment and to the followup treatment. There is a possibility that some readers may question a specific subject, especially if the individual reader may have had much experience working in a hospital emergency department. An example of this is the statement, "Hypertension emergencies are rare. They occur in fewer than 1 percent of patients with high blood pressure." National statistics have shown that there are 30,000,000 individuals in the United States with hypertension.

It is interesting to note that 70 percent of the contributors are instructors in an eastern medical school.

Jack R. Karel, M.D.

Fundamentals of Family Medicine

Robert B. Taylor, M.D., (ed). New York, NY, Springer-Verlag, 1983. Pp. 488. Illustrated. ($34.50)

This paperback volume represents an extract from a more complete work entitled, *Family Medicine: Principles and Practice*, and is intended for the medical student. It presents a broad overview of the range of courses of the medical school curriculum from the clinical view of the well-trained family physician, addressed particularly to the development of the behavior, concepts, and skills necessary to the specialty. Starting with the basic family doctor relationship, the need for a family physician, interfamily dynamics in health and disease, and interesting case descriptions of the physician's role, this book explores such topics as the natural history of disease, comprehensive and continuous care, care at various stages of the family's life cycle, and normal changes with aging.

There are interesting chapters on counseling during periods of death and bereavement (including hospice), premarital, marital, sexual, genetic, nutrition, and health maintenance. Brief chapters on problem solving, physical diagnosis, and use of the laboratory are presented as introductions to these subjects, as are electrocardiography and newer modes of diagnostic roentgenology.

References to the medical literature are presented after each subchapter, and a subject index is at the end of the book.

This volume, as part of the complete work, appears to be a valuable student textbook for those wishing to understand the broad discipline of family medicine and for those contemplating residency training in the specialty.

Joseph Peyser, M.D.

Health and Human Values: A Guide to Making Your Own Decisions

Frank Harron, John Burnside, Tom Beauchamp. New Haven, CT, Yale University Press, 1983. Pp. 194. ($24.95)

This small book provides an introduction for a general audience to complex health issues in the hope that its readers will be better prepared to cope in an era of values transition. The authors (an Episcopal priest, an internist, and a philosopher) collaborate to provide a variety of perspectives. Their style is lucid and focuses on the following issues: moral decision making, euthanasia, abortion, health care

and distributive justice, truth telling and informed consent, determination of death, and genetic engineering.

Each chapter includes illustrative cases and an excellent selection of annotated references. The text is supplemented by three inexpensive paperbacks which give additional background material; these include a leader's manual, a digest of excerpted landmark legal decisions, and an audio-visual resource manual.

Preparation of these texts was sponsored by the Society for Health and Human Values of the United Ministries in Education. These organizations aim to provide the general public with reliable information so that citizens can make their own informed decisions. Towards this end, this book succeeds admirably and it should also prove to be useful and thought provoking for the interested professional as well as the layperson. Michael Nevins, M.D.

Male Reproduction and Fertility

Andres Negro-Vilar (ed). New York, NY, Raven Press, 1983. Pp. 390.

Although the chapters of this compendium are not in physiologic order, it drives home a point regarding the complexity of male reproductive neuroendocrinology (andrology). The first chapters review in detail the deleterious effects of hyperprolactinemia in male fertility. Hormonal release mechanisms from the hypothalamic-pituitary system are addressed including the adrenergic-cholinergic receptor areas and the effects of gamma aminobutyric and hydroxybutyric acids. It is interesting to note that calcium channel blockers (when locally applied) can depress prolactin release from rat hypothalamus. Thus, we may wonder about the reproductive/sexual implications of the recently used calcium channel blockers for coronary spasms.

This book also reiterates the importance of hormonal circadian pubescent-senescent rhythmic male fertility pattern and elucidates the harmful effects in the male offspring following maternal exposure to marijuana and alcohol. The biochemistry of prostate protein, kinases, and its androgenic action are discussed with the possible use of buserelin—an LHRH agonist as a treatment alternative for prostate CA.

One of the exciting chapters deals with the newest medical fertility treatment innovations of idiopathic normogonadotropic oligozoospermia. The first therapy is kallikrein and if no response after 3 months, the following drugs are suggested at 3, 6, and 12 month intervals, i.e. mesterolone, MHG + HCG, tamoxifen, and artifical insemination. Finally, the discussion of male inhibitory material (MIM) as the possible cause of autoimmune sterility is a challenge to the fertility physiologists.

This text is research oriented; however, the clinical reproductive endourologists, obstetricians, and immunologists would benefit most in the assessment of male infertility, sperm cryopreservation, and artificial insemination of different types of sperm origin and population. J.F.J. Leyson, M.D.
Director of Sex Clinic
VA Medical Center, East Orange

Medicine for the Practicing Physician

J. Willis Hurst (ed). Woburn, MA, Butterworth Publishers, 1983. Pp. 1,969. Illustrated. ($80)

What a delight to pick up a new textbook on medicine for the practicing physician—with a new approach, a new format, and a new design for teaching, reading, and review. And there is even a surprise: the paragraph at the end of many of the subjects discussed describes "cost containment." Quality assurance has arrived to stay and become an active part in teaching. Today's physician must learn the reasonable cost of health care for the patient, both in the office and during hospital stay.

Medicine for the Practicing Physician is massive in size. Included are indepth lectures by contributors from the faculty of Emory University School of Medicine and from surrounding teaching hospitals in the Atlanta, Georgia area.

This edition is the beginning of a new way of thinking and collection of thoughts and ideas in the sequence of learning and study of medicine. The lesson plan composes diagnostic criteria; clinical evaluation both subjectively and objectively; plans for diagnostic and therapeutic approach; followup patient care after hospital release; a review of basic science and natural history of the illness; preventive care; and the "cost containment" factor of getting the best and most efficient cure for the least cost.

The reading is easy; the lectures are all well composed with adequate cross-references on every subject. Chapters are divided into topics dealing with a particular illness or a preventive problem. Subjects are reviewed by a formidable staff and the result is gratifying and well done.

As a practicing physician for more than 30 years, I have seen many new texts, but never one so skillfully composed for study, review, and learning both for students as well as established practitioners. It is a good investment for continued medical education and review.

Harry M. Poppick, M.D.

Practical Infectious Diseases

Richard D. Meyers, M.D., (ed). New York, NY, John Wiley and Sons, 1983. Pp. 254. ($14.95)

This small book is one of a series dealing with all nine medical subspecialties. Most of the authors are from the UCLA Medical School.

There are 12 chapters divided into three parts: common clinical infections; antibacterial chemotherapy; and viral infections and viral chemotherapy. There is an excellent chapter on legionnaires' disease emphasizing the differential diagnosis with *Streptococcus pneumoniae* and *Mycoplasma pneumoniae*. On the other hand, the discussion of other pulmonary infections is inadequate. Also, there are no presentations of many other infections, such as those from travel, animals, skin infections, and AIDS. In fact, this book is little more than what one would expect from a series of lectures for medical students.

I cannot recommend *Practical Infectious Diseases;* it would be better to buy a more complete reference book on the subject.

Dominic A. Mauriello, M.D.

OBITUARIES

Drs. Anthony; Chanin; Esposito; Gross; Halperin; Henderson; Karshmer; Kler; Kostant; Ladas; McCue; Meltsner; Rusin; Stein; and Walters

Dr. David W. Anthony

At the grand age of 90, David Wesley Anthony, M.D., died on September 25, 1983. A retired member of our Middlesex County component, Dr. Anthony was a 1924 graduate of Howard University College of Medicine, Washington, D.C. A family practitioner, Dr. Anthony was a member of the American Medical Association. He was a recipient of MSNJ's Golden Merit Award for 50 years of medical service to his community.

Dr. Israel L. Chanin

Word has been received of the death of Israel Levick Chanin, M.D., a member of our Hudson County component, on April 10, 1983. Born in 1908, Dr. Chanin earned a medical degree at Lausanne Medical School, Switzerland, in 1939. During his career, Dr. Chanin was affiliated with Jersey City Medical Center. A member of the American Medical Association, Dr. Chanin also served as a medical inspector for the Board of Health.

Dr. Joseph I. Esposito

At the age of 64, Joseph Irwin Esposito, M.D., died on December 10, 1983. Dr. Esposito earned his medical degree at Hahnemann Medical College, Pennsylvania, in 1951. A family practitioner, Dr. Esposito served the Hammonton community since 1952. Dr. Esposito was a member of our Atlantic County component and of the American Medical Association. During his career, Dr. Esposito was affiliated with Kessler Memorial Hospital, Hammonton.

Dr. Arthur F. Gross

Arthur Franklin Gross, M.D., a member of our Passaic County component, died on September 6, 1983. Born in 1900, Dr. Gross received his medical degree from Seton Hall College of Medicine and Dentistry in 1961. An internist, Dr. Gross was affiliated with St. Joseph's Hospital and Medical Center, Paterson, and Chilton Memorial Hospital, Pompton Plains. Dr. Gross was a member of the American Medical Association.

Dr. David Halperin

Word has been received of the death of David Halperin, M.D., a retired member of our Hudson County component. Born in 1908, Dr. Halperin earned his medical degree at the University of Maryland School of Medicine in 1932. During his career, Dr. Halperin was affiliated with Jersey City Medical Center and was a member of the American Medical Association.

Dr. George T. Henderson

George T. Henderson, M.D., assistant medical director of Roosevelt Hospital, Edison, died on December 14, 1983. Dr. Henderson was a member of our Middlesex County component. Born in 1921, Dr. Henderson earned his medical degree at New York University School of Medicine in 1945. An anesthesiologist, Dr. Henderson was affiliated with Middlesex General Hospital and St. Peter's Medical Center, both in New Brunswick. He was a Diplomate of the American Board of Anesthesiology, a member of the American Medical Association, and a Fellow of the American College of Anesthesiologists.

Dr. Nathan Karshmer

A retired member of our Middlesex County component, Nathan Karshmer, M.D., died on November 29, 1983. Born in 1902, Dr. Karshmer was awarded a medical degree from George Washington University School of Medicine, Washington, D.C., in 1924. A gynecologist, Dr. Karshmer was affiliated with St. Peter's Medical Center and Middlesex General Hospital, both in New Brunswick. Dr. Karshmer was a member of the American Medical Association, and a Fellow of the American College of Surgeons, of the American College of Obstetricians and Gynecologists, and of the International College of Surgeons.

Dr. Joseph H. Kler

On November 21, 1983, Joseph Henry Kler, M.D., died . Dr. Kler was the author of *The Journal's* column entitled, "Medical Philately." Born in 1902, Dr. Kler earned his medical degree at the University of Pennsylvania School of Medicine in 1928. During his lengthy career, Dr. Kler was affiliated with Middlesex Hospital and St. Peter's Medical Center, both in New Brunswick. Dr. Kler was a recipient of MSNJ's Golden Merit Award for 50 years of service to the community. A member of our Middlesex County component and of the American Medical Association, Dr. Kler was a Diplomate of the American Board of Otolaryngology and a Fellow of the American College of Surgeons.

Dr. George H. Kostant

George Harold Kostant, M.D., a prominent South Orange dermatologist, died on December 1, 1983. Born in 1916, Dr. Kostant earned his medical degree at Duke University, North Carolina, in 1940. A member of our Essex County component and of the American Medical Association, Dr. Kostant was affiliated with General Hospital, Irvington, Saint Barnabas Medical Center, Livingston, and the Veterans Administration Medical Center, East Orange. Dr. Kostant was a Diplomate of the American Board of Dermatology.

Dr. George Ladas

At the age of 81, George Ladas, M.D., died on November 23, 1983. Dr. Ladas was a gynecologist affiliated with Saint Barnabas Medical Center, Livingston, and Elizabeth General Medical Center, for over 50

years. Dr. Ladas received his medical degree from Cornell University Medical College, New York, in 1927. A member of our Union County component and of the American Medical Association, Dr. Ladas was a recipient of MSNJ's Golden Merit Award for his years of service to the medical community.

Dr. John B. McCue

John Beebee McCue, M.D., a member of our Passaic County component, died on November 18, 1983, as a result of a plane crash. Dr. McCue was 76 years old. He received his medical degree from Johns Hopkins Medical School, Maryland, in 1933. Dr. McCue retired from active practice after 50 years of service; he was a recipient of MSNJ's Golden Merit Award. During his career, Dr. McCue was affiliated with Chilton Hospital, Pompton Plains, and St. Joseph's Hospital and Medical Center, Paterson. A member of the American Medical Association, Dr. McCue was a Diplomate of the American Board of Family Practice and a Fellow of the American Academy of Family Practice.

Dr. Louis Meltsner

Louis Meltsner, M.D., a retired member of our Hudson County component, died last year. Dr. Meltsner graduated from Columbia University College of Physicians and Surgeons, New York, in 1923. A radiologist, Dr. Meltsner retired from practice in 1975. He received MSNJ's Golden Merit Award for his years of service. A Diplomate of the American Board of Radiology, Dr. Meltsner was a member of the American Medical Association.

Dr. Michael J. Rusin

On December 13, 1983, Michael Joseph Rusin, M.D., died. Dr. Rusin was born in 1917 and earned his medical degree in 1943 from New York University School of Medicine. A family practitioner, Dr. Rusin was affiliated with General Hospital, Passaic.

Dr. Arthur H. Stein

At the untimely age of 50, Arthur Henry Stein, M.D., died on December 2, 1983. He was chief of medical services at Atascadero State Hospital since 1979 and was previously in private practice for 26 years. Dr. Stein graduated from Downstate Medical College, New York, in 1933. A member of our Bergen County component, Dr. Stein was a Diplomate of the American Board of Psychiatry and was affiliated with Englewood Hospital.

Dr. George M. Walters

Word has been received of the death of George Myron Walters, M.D., a retired member of our Middlesex County component. Born in 1896, Dr. Walters received his medical degree from Syracuse University Medical School, New York, in 1922. During his career, Dr. Walters was affiliated with Rahway Hospital, and was a member of the American Medical Association.

AUTHOR INFORMATION

Style Sheet

The Journal is the official organ of the Medical Society of New Jersey. The goals of* The Journal *are educational and informational. All material published in* The Journal *is copyrighted by MSNJ.

CONTENT

The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports based on unusual clinical experiences; review articles; clinical notes, succinct items on some aspect or new observation or technique of a case experience; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update; and an opinion column. Editorials are prepared by the Editor and by guest contributors on timely and relevant subjects; editorials are the responsibility of the author. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the Editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made in New Jersey.

ASSIGNMENT OF COPYRIGHT

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978), a transmittal letter or a separate statment accompanying material offered to *The Journal* of the Medical Society of New Jersey must contain the following language and must be signed by all authors:

"In consideration of *The Journal* of the Medical Society of New Jersey taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *The Journal*, MSNJ."

SPECIFICATIONS

Submit two **manuscripts** that must be typewritten and double-spaced on 8½" by 11" paper. Statistical methods used in articles should be identified. Acknowledgements will be made only for specific preparation of an essential part of the manuscript.

Authors are asked to seek clarity, accuracy, and originality; attention to details of grammar, spelling, and typing are important.

The **title page** should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

The author should submit a 40-word **abstract** to be used at the beginning of the article.

Tables must be typewritten and double-spaced on separate 8½" by 11" sheets, with a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source; written permission for republication from the original publisher must be submitted. The cost of color photographs must be borne by the author.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

The **summary** of the article should not exceed 250 words; it should contain only essential facts.

References should not exceed 35 citations except in review articles, and should be cited consecutively in the text by numbers in parentheses at the end of the sentence. The reference list should be typewritten and double-spaced on separate 8½" by 11" sheets in the numerical order in which they are first cited in the text. The style of reference is that of *Index Medicus*:

1. Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, NY, McGraw-Hill, 1969, pp. 42-48.

PUBLICATION POLICY

Receipt of each manuscript will be acknowledged and a copy delivered to the Editor who refers the paper to one or more members of the Editorial Board. The final decision is reserved for the Editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. Galley proofs will be submitted to the author for correction of typographical errors.

REPRINT ORDERS

Reprints may be ordered after the author is notified that the article has been selected for a specific issue of JMSNJ. A check for the cost of reprints including remake charge if order is received after due date must accompany the order.

COMMUNICATIONS

All communications should be sent to the Editor, *The Journal*, MSNJ, 2 Princess Road, Lawrenceville, NJ 08648.

TAXES AND ACCOUNTING
AFFECT YOUR PROFITABILITY!

GEIN, CONNOLLY & SWITAJ

Certified Public Accountants

Central New Jersey CPA Firm Providing Tax, Accounting and Management Advisory Services to the Medical Profession.

721 North Beers Street
Holmdel, New Jersey 07733
(201) 739-2020

PROGESTERONE SUPPOSITORIES
25 mg., 50 mg., 100 mg., 200 mg., & 400 mg.
Boric Acid Suppositories 600 mg.

in Polyethylene Glycol Base for Vaginal Use, are now being compounded at the following Pharmacy

Hidden Lakes Pharmacy

2039 Rt. #27, Somerset, N.J. 08873 201-821-8500
Howard L. Rubenstein, R.Ph.

Specific dosage and ingredient requirements can be tailored to your patients needs. We specialize in compounding prescriptions.

Delivery available to your patients home. Call for details.

OFFICE SUITE

Millburn Ave., Maplewood-small prof. bldg. 1 suite avail. Approx. 1000 sq. ft. $1,200.00 mth.—set for M.D., etc. 3 trmt. rms., sml. kitchen, x-ray rm., lav., waiting rm., Nurse station & storage—1st flr.

Call L.L. Leifer, Esq., Days (201) 763-8555, Eve. (201) 325-8630.

TWO MEDICAL SUITES

Available June 1st—Livingston Avenue (Doctors' Row)—New Brunswick, NJ. Both suites fully carpeted, sink, closets in each room. One suite has X-Ray room with equipment.

For Information Please Call
201-828-2715

It's A Major Medical Explosion

The Lakewood, Toms River and Point Pleasant hospitals are all going ahead with major expansion programs . . . Bricktown to build new facility.

Cross River Professional Center

400 to 2,300 Square Feet

¼ Mile South of Kimball Medical Center

- $9 to $11 per square foot
- Graduated rent schedules
- Ownership options available
- Fully landscaped
- Centrally located and 10 minutes to three major hospitals
- Private entrances and all services available
- Equipment leases available

BARRYMOR ENTERPRISES Brokers Protected

1200 River Avenue (Route 9), Lakewood, NJ 08701 • (201) 367-2226

The New Jersey Academy of Family Physicians

announces its

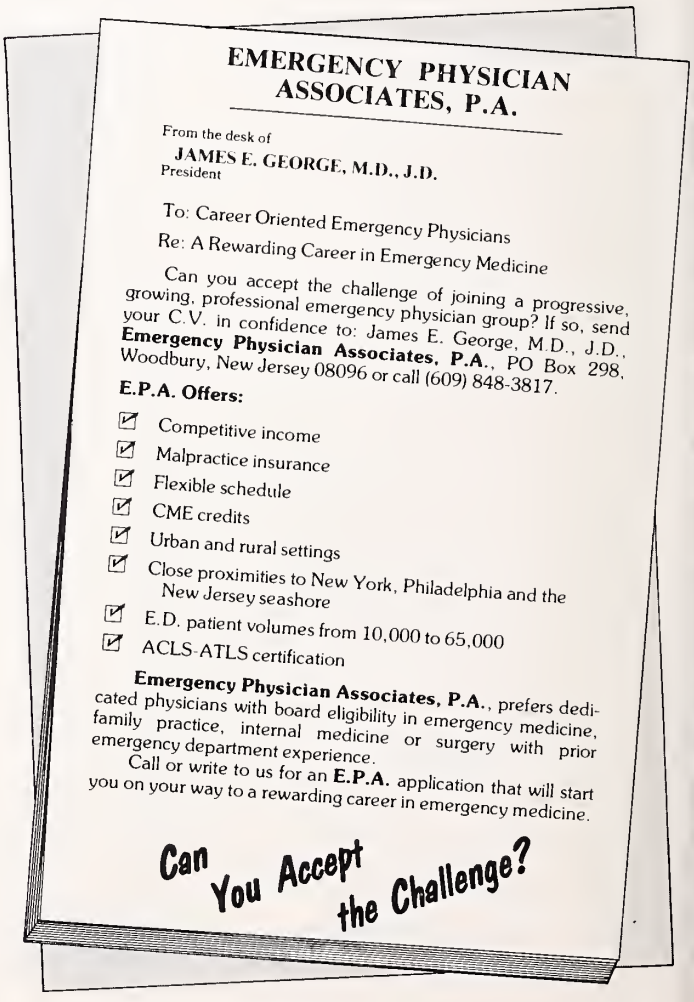
MD PLACEMENT SERVICE

Any physician, hospital or community having a POSITION AVAILABLE due to retirement, desire for addition of a partner or to perceived community need or for any other reason may apply.

Any family physician desiring knowledge of a New Jersey POSITION AVAILABLE for practice may apply.

Interested physicians should write to:

Physician Placement Service, NJAFP, c/o Frank C. Snope, MD, Department of Family Medicine, UMDNJ—Rutgers Medical School, CN 19, New Brunswick, N.J. 08903



CLASSIFIED ADVERTISEMENTS

DIAGNOSTIC RADIOLOGIST—Board certified, trained in general diagnosis, nuclear medicine, special procedures, C.T. and ultrasound. Available full or part-time; group practice or hospital based; North or Central New Jersey. Can also provide mobile ultrasound and office consultation. Reply to Box No. 63, JMSNJ.

GENERAL PRACTITIONER—Desires industrial, pharmaceutical or similar position. Semi-retired, age 55, (201) 545-4339.

GENERAL SURGEON—Board certified, wishes to join another surgeon or a group in area of Monmouth County or adjoining counties. If interested please contact Dr. Hasan (201) 972-1584.

INTERNIST—Board eligible internist wants a hospital/clinic or health center position in Northern New Jersey. For further information, write Box No. 67, JMSNJ.

INTERNAL MEDICINE—Board eligible, general internist with extensive emergency room experience seeking group practice of internal medicine or emergency room position. Northern New Jersey area. Available July 1984. Please call (212) 645-4616, Steven Wolinsky, M.D. Curriculum vitae and references available upon request.

INTERNIST—Seeking small group practice. Internal medicine, 1½ hours from New York City in NY, CT, NJ. Boston and NYC University Hospital trained. Boston University MD Cum Laude, 1981. ABIM eligible and available July 1984. Contact Box No. 70, JMSNJ.

OPHTHALMOLOGIST—Board eligible, July 1984, Board certified Pediatrics (1982), age 29, desires partnership or group. Available July 1984. Write Box No. 65, JMSNJ.

PEDIATRIC DIABETOLOGIST/ENDOCRINOLOGIST—Seeks association, partnership with established physician in New York metropolitan area. Please phone after six 617-738-6205.

PHYSICIAN—Retired, MD, age 60, seeks part or full time job in South Jersey. Prefer institutional, outpatient or insurance work. Telephone 609-927-7782 or 609-927-1873.

NEEDED DISABILITY EVALUATION PHYSICIAN—South Jersey area. Some experience in trauma and orthopedic diagnosis. Part-time with flexible schedule. Hourly stipends. Write Box No. 68, JMSNJ.

NEEDED FAMILY PHYSICIAN—Board eligible, for partnership in one of the largest family practice facilities in New Jersey. Please send resume to Box No. 69, JMSNJ.

NEEDED ASSOCIATE—Pediatrician, board certified; seeks associate, board certified/eligible, to join well established practice. Excellent opportunity. Northern New Jersey near New York City. Write Box No. 40, JMSNJ.

NEEDED PRIMARY CARE PHYSICIANS—Private fee-for-service practice in new, fully equipped suburban offices. All personal supplies, and management services provided. This is an excellent opportunity for physicians with a good "bedside" manner interested in developing a lucrative practice and still desiring time for the pursuit of happiness. Reply to: Neighborhood Doctor Corporation, 901 Long Beach Blvd., Ship Bottom, NJ 08008.

NEEDED RADIOLOGIST—Part time, 2 mornings per week. Ocean County. Prefer competent retired person. Write Box No. 62, JMSNJ.

ALLERGY PRACTICE—Allergist certified or board eligible for Purchase of very desirable Practice, child and adult. Central NJ. Write Box No. 47, JMSNJ.

PRACTICE FOR SALE—ENT, established 16 years. Fully equipped modern office. Excellent location. Terms available. Deceased-immediate. Vineland, NJ. Close to Atlantic City and Philadelphia (609) 692-2536, (609) 696-8681.

PRACTICE—SPECIAL OPPORTUNITY—Large beautiful office, fully furnished and equipped. Excellent location at bus stop and near hospital. Can service 1 or 2 doctors, other health career personnel or other profession. Available due to physician's death. Patients waiting. Contact Mrs. L. Friedman, 18th and Northampton Streets, Easton, PA 18042. Phone 215-252-6341.

PRACTICE FOR SALE—Pediatrics. Long established practice, ½ block from hospital. Property and equipment. Located in Middlesex County. Will introduce. Write Box No. 64, JMSNJ.

PRACTICE FOR SALE OR RENT—Family Practice, for sale or rent office and equipment. Near a 550 bed teaching hospital in Monmouth County. Call after 6 P.M. (201) 681-2566.

EQUIPMENT—3M 209 copier with automatic feed, in very good condition. 2 rolls of intermediate paper. Does book copying. Up to 25 copies. $475.00. 201-725-6113.

OFFICE SPACE SHARED NEEDED—Board certified internist desires office space in Camden County (Cherry Hill, Haddonfield area) or Salem County area. Call Dr. Chen (513) 475-4368.

OFFICE SPACE—Professional office to sublet—1420 square feet, prime growth area of Bridgewater. Ideal for urologist, otolaryngologist, nephrologist, other professional. Available March or April. 201-725-6113.

OFFICE SPACE—Edison, 1,214 square feet, 8 room, bathroom, carpeted, near all highways and hospitals, on-site parking. Available immediately. Call Dr. Bronstein (201) 738-8000.

OFFICE FOR RENT—Edison, 1,300 square feet, new building, 172 Amboy Avenue. Ample parking, no steps. Near Perth Amboy and JFK hospitals. Call (201) 442-4444.

OFFICE SPACE—Moorestown, NJ. Victoria Medical Arts Building. Renting custom medical offices in new building. Ideal for radiologists, orthopedist, urologist, general surgeon, industrial physician. Excellent location and parking. Call (609) 235-2651.

OFFICE FOR RENT—Professional office for rent, approximately 710 square feet near Dover General Hospital. Near Routes 80 and 46. Morris County, NJ. Telephone (201) 366-2557.

OFFICE SPACE TO SHARE—Morristown, central location. Near hospital, fully equipped, newly decorated. All utilities included. Ample parking available. Near public transportation. Available immediately. (201) 267-2555.

OFFICE SPACE—North Haledon. Two side by side 750 square feet suites available in professional building close to Paterson General Hospital. Immediate occupancy. Will alter to suit or Purchase the entire 3000 square foot building. Free basement storage. Call (201) 427-7500.

FOR SALE—OFFICE SPACE. Roselle, modern 2,400 square feet, 6 treatment rooms and 4 consultation rooms. On-site parking. Warinanco Medical Building. Phone (201) 687-0102.

OFFICE SPACE—Southern New Jersey, Gloucester Township, Camden County. Office suite in new medical building for rent. 1,000 or 2,000 square foot suites available. Located in rapidly growing, highly desireable area, near several large hospitals. Ideal for family practice or specialist. Building to be completed late 1984. Call Dr. Ribatsky 609-227-2221.

OFFICE SPACE—For immediate occupancy new, modern, energy efficient rental 500 to 2,000 square feet available from $5 per foot. 31,000 residents within three mile radius. Close to Philadelphia, Atlantic City in Central Jersey shore area. Internists and specialities needed. Ideal for main/satellite office. Call (201) 350-1008.

OFFICE SPACE TO SHARE—Westfield, central location. Near hospital, fully equipped, attractively decorated. All utilities included. Ample parking available. Near public transportation. Available immediately. (201) 267-2555.

FOR SALE—Boat. 1982 Sea Ray Sedan 26 foot, all extras. Call (201) 864-7172.

Need A Temporary Physician?

CompHealth treats your practice as if it were our own during: vacations, CMEs, recruiting, clinic start-up or other absences.

Want Free Time While You Practice Medicine?

Join CompHealth's Locum Tenens Physician Group.

★

For further information about temporary coverage or locum tenens practice opportunities, call:

CompHealth

A Physician Group

WILSON ROSS, Regional Administrator
114 Centennial Avenue
Sewickley, PA 15143
Telephone: 412/741-3310

A special practice for specialists

If you're a surgeon or OB/GYN or other medical specialist, the Air Force may have a special practice for you.

What makes it special? You'll enjoy an excellent pay and benefits package. Your regular working hours will allow you to spend more time with your family. You'll receive 30 days of vacation with pay each year. And you will work with modern equipment and some of the most highly trained professionals in the world, serving your country and your patients. Now that's special!

Call: Tsgt Steve Porter
201-790-8117

AIR FORCE
A great way of life.

PHYSICIANS

U.S. NAVY MEDICAL DEPARTMENT
An Equal Opportunity Employer

Positions are presently available in the following areas:

- General surgery & Surgical Specialties
- Ortho Surgery
- Pathology
- Anesthesiology
- Neurology
- Family Practice
- Other Specialties
- Preventive/Occupational Medicine

NAVY MEDICINE

- Provides the qualified physician with the opportunities to become a member of global health care system.
- Is practiced in excellent medical facilities in conjunction with a highly professional staff of support personnel.
- Allows the physician the advantage of experiencing all aspects of medicine including teaching, research, administration and graduate medical education without the associated career disruption.
- Provides the physician with an officer's commission with attendant benefits and privileges.

Basic qualifications for a commission as a NAVY physician include U.S. citizenship and excellent professional references.

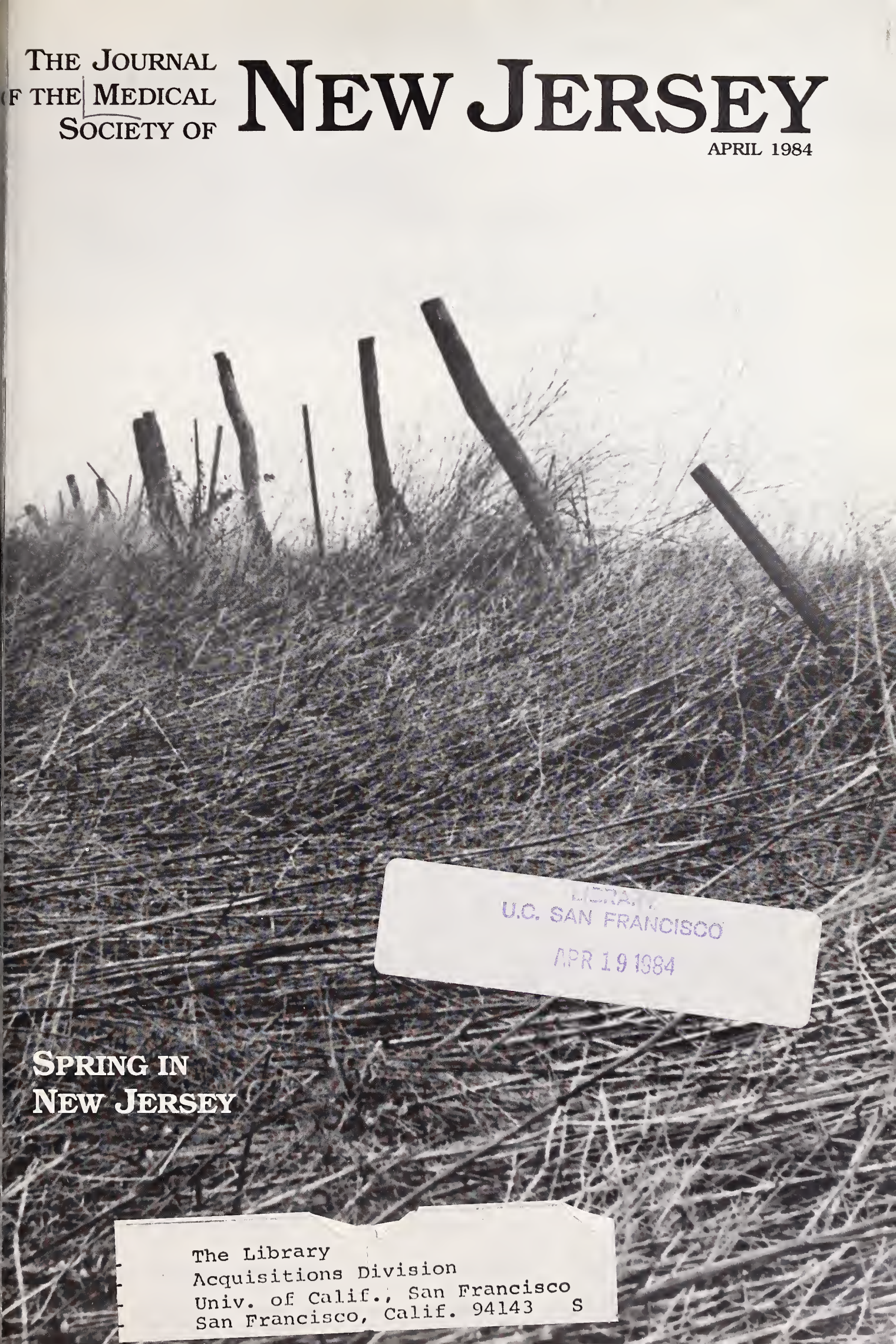
For a preliminary review of your qualifications, send your curriculum vitae to:

MEDICAL PROGRAMS, CODE MD20
NAVY RECRUITING DISTRICT
128 NORTH BROAD STREET
PHILADELPHIA, PA 19102
(COLLECT) (215) 568-2042
ATTN: LT PAT DAY

THE JOURNAL OF THE MEDICAL SOCIETY OF

NEW JERSEY

APRIL 1984



U.C. SAN FRANCISCO
APR 19 1984

SPRING IN NEW JERSEY

The Library
Acquisitions Division
Univ. of Calif., San Francisco
San Francisco, Calif. 94143 S

Send this coupon for no-obligation information of the savings under the Medical Society of New Jersey Endorsed Insurance Plans

Check this list against your coverages . . . .

- ☐ $5000 Monthly Guaranteed Convertible Accident and Health
- ☐ $10,000 Monthly Practice Overhead Expense
- ☐ $1,250,000 Term Life Insurance
- ☐ $500 Deductible COMPREHENSIVE MILLION-DOLLAR MAJOR MEDICAL PLAN—No other coverage needed—Issuable to Age 69
- ☐ $15,000 Deductible MILLION-DOLLAR UMBRELLA MAJOR MEDICAL PLAN for holders of Blue Cross and other Major Medical Plans—Issuable to Age 69
- ☐ $100-a-day Hospital Income Policy
- ☐ $200,000 High Limit Accident Plan
- ☐ Keogh and Corporate Plan NOW! $15,000 KEOGH

E. & W. Blanksteen Agency, Inc.

E. & W. Blanksteen
75 Montgomery St.,
Jersey City, N.J. 07302
(201) 333-4340
or (800) 742-2849

Name: _____

Address: _____

_____

Tel. No. _____

Best Time To Call _____

The IBM Personal Computer
A tool for modern times
In the Medical Office.

MEDI-SCAN®, an Authorized IBM® Value-Added Dealer for the Personal Computer

For Comprehensive $8,995.00 MEDI-SCAN In-office Billing And Accounting System Includes:

The IBM Personal Computer XT with 128K, 10 Megabyte hard disk.

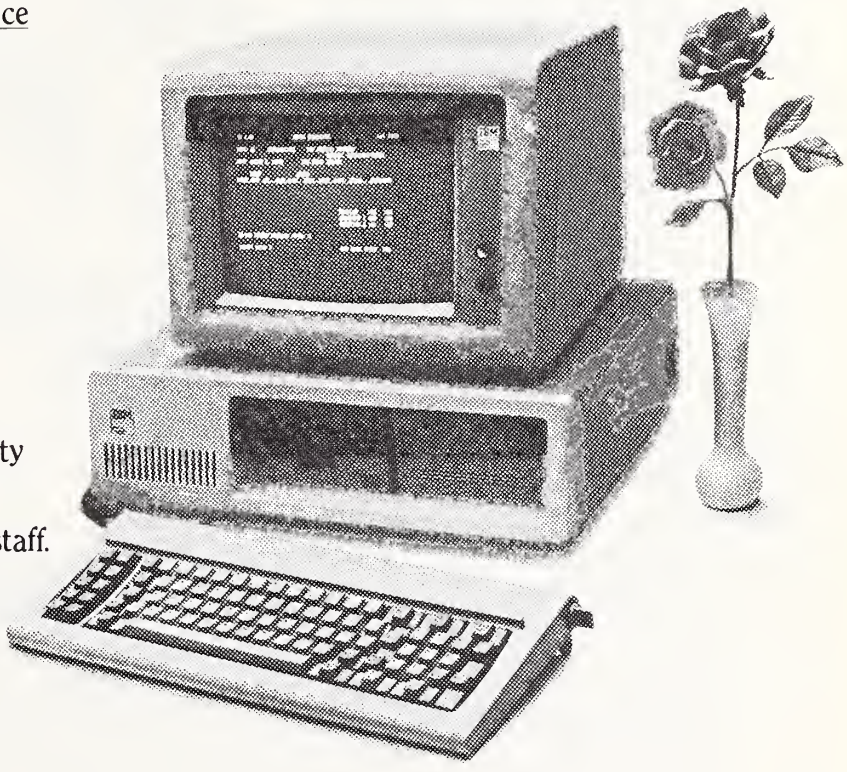
The IBM Graphics Printer.

MEDI-SCAN software—customized for your practice, including procedure numbers for state agencies. Generates accounting reports, comprehensive patient statements, insurance and third party forms.

Optional electronic paperless billing to third party agencies, where applicable.

Training—Complete in-office training for your staff.

Support—"HOT-LINE" 800 number for continuous support.



MEDI-SCAN Single Source Support System

MEDI-SCAN'S unique, comprehensive hardware and software maintenance agreement guarantees continuing service and repair, system updates and additional customization, plus in-office training—all from one source. Our total training consultants and technicians are dedicated to giving you the best possible service.

IBM Personal Computer XTs are in stock in our local warehouses ready to be immediately installed. Over three hundred physicians are using the MEDI-SCAN System—join them in making the IBM PC-XT "A tool for modern times in the medical office."

Networking available for group practices and clinics

I would like to know more about the MEDI-SCAN System on the IBM Personal Computer XT.

Dr. _____

Address _____

City _____ State _____ Zip _____

Phone (____) _____

Or call: 800-922-1021
In MA: 800-462-1009

Send to: **MEDI-SCAN**
90 Madison Street, Worcester, MA 01608

IBM Authorized Value Added Dealer Personal Computers

MEDI-SCAN®

Service centers currently in: *New England* · *Mid Atlantic States* · *Mid Western States* · *California* · *Texas*

®MEDI-SCAN is a registered trademark of PAL Assoc. Inc.
PAL Associates is an Authorized IBM Value-Added Dealer for the Personal Computer.
®IBM is a registered trademark of International Business Machines Corporation.

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

Officers and Trustees

PRESIDENT
Alexander D. Kovacs, M.D. (Union) ..... Scotch Plains
PRESIDENT-ELECT
Frank Y. Watson, M.D. (Essex) ..... Glen Ridge
FIRST VICE-PRESIDENT
Ralph J. Fioretti, M.D. (Bergen) ..... Rochelle Park
SECOND VICE-PRESIDENT
Edward A. Schauer, M.D. (Monmouth) ..... Farmingdale
IMMEDIATE PAST-PRESIDENT
Howard D. Slobodien, M.D. (Middlesex) ..... Metuchen
SECRETARY
Arthur Bernstein, M.D. (Essex) ..... South Orange
TREASURER
Paul J. Hirsch, M.D. (Somerset) ..... Bridgewater

Trustees

Douglas M. Costabile, M.D.,
Chairman (1984) (Union) ..... Murray Hill
Frank Campo, M.D. (1984) (Mercer) ..... Trenton
Harry M. Carnes, M.D. (1985) (Camden) ..... Audubon
Joel S. Cherashore, M.D. (1986) (Essex) ..... Nutley
John J. Crosby, Jr., M.D. (1984) ..... Jersey City
Palma E. Formica, M.D. (1984)
(Middlesex) ..... New Brunswick
Harry W. Fullerton, Jr., M.D. (1985)
(Salem) ..... Carney's Point
Frank Gingerelli, M.D. (1986) (Bergen) ..... Hackensack
William Greifinger, M.D. (1984) (Essex) ..... Belleville
John P. Kengeter, M.D. (1984) (Ocean) ..... Toms River
Edwin W. Messey, M.D. (1985) (Burlington) ..... Willingboro
Myles C. Morrison, Jr., M.D. (1985) (Morris) ..... Morristown
John J. Pastore, M.D. (1986) (Cumberland) ..... Vineland
Michael R. Ramundo, M.D. (1984) (Passaic) ..... Clifton

Councilors

FIRST DISTRICT
(Essex, Morris, Union, and Warren Counties)
Edward M. Coe, M.D. (1984) ..... Cranford
SECOND DISTRICT
(Bergen, Hudson, Passaic, and Sussex Counties)
Robert A. Weinstein, M.D. (1986) ..... Newton
THIRD DISTRICT
(Hunterdon, Mercer, Middlesex, and Somerset Counties)
Albert F. Moriconi, M.D. (1985) ..... Trenton
FOURTH DISTRICT
(Burlington, Camden, Monmouth, and Ocean Counties)
Frederick W. Durham, M.D. (1984) ..... Haddonfield
FIFTH DISTRICT
(Atlantic, Cape May, Cumberland, Gloucester, and
Salem Counties)
Paul H. Steel, M.D. (1986) ..... Atlantic City

AMA Delegates

William J. D'Elia, M.D., *Chairman* (1985) ..... Spring Lake
Alfred A. Alessi, M.D. (1984) ..... Hackensack
Frederick W. Durham, M.D. (1984) ..... Haddonfield
Palma E. Formica, M.D. (1984) ..... New Brunswick
Karl T. Franzoni, M.D. (1984) ..... Trenton
John S. Madara, M.D. (1984) ..... Salem
Henry J. Mineur, M.D. (1984) ..... Cranford
Myles C. Morrison, Jr., M.D. (1985) ..... Morristown
Howard D. Slobodien, M.D. (1985) ..... Metuchen

AMA Trustee

James S. Todd, M.D. (Ridgewood) ..... Bergen

April 1984

Publication Committee

Paul J. Hirsch, M.D., *Chairman*
Dirck L. Brendlinger, M.D.
Frederick B. Cohen, M.D.
A. Olusegun Fayemi, M.D.
Robert M. MacMillan, M.D.
Leon G. Smith, M.D.
La Verne Fioretti

Editor

Arthur Krosnick, M.D.

Managing Editor

Geraldine R. Hutner

Assistant Managing Editor

Dorothy J. Griffith

Advertising Manager

E. Elizabeth Cookson

Executive Director

Vincent A. Maressa

Executive Director Emeritus

Richard I. Nevin

Editorial Board

Jerome Abrams, M.D. (Obstet/Gynecol)
Joseph Alpert, M.D. (Vasc Surg)
Harold Arlen, M.D. (Otolaryngol)
Alfonse Cinotti, M.D. (Ophthalmol)
Robert Dodelson, M.D. (Nephrol)
Wm. A. Dwyer, Jr., M.D. (Surg)
Norman H. Ertel, M.D. (Int Med/Endocrinol)
Daniel P. Greenfield, M.D. (Psychiat)
Christine E. Haycock, M.D. (Sports Med)
Monroe S. Karetzky, M.D. (Pulmon Med)
Avrum L. Katcher, M.D. (Pediatr)
Stanley C. Leonberg, Jr., M.D. (Neurol)
Joel D. Levinson, M.D. (Gastroenterol)
Henry R. Liss, M.D. (Neurosurg)
Geobel A. Marin, M.D. (Int Med/Gastroenterol)
Donald G. McKaba, M.D. (Allergy)
Robby Meijer, M.D. (Plas Surg)
Frank T. Padberg, Jr., M.D. (Surg)
Christopher A. Papa, M.D. (Dermatol)
Norman Riegel, M.D. (Book Review)
Edwin L. Rothfield, M.D. (Cardiol)
Benjamin F. Rush, Jr., M.D. (Surg)
Morris H. Saffron, M.D. (Med His)
Mark M. Singer, M.D. (Int Med/Endocrinol)
Sheldon D. Solomon, M.D. (Rheum)
Lloyd N. Spindell, M.D. (Radiol)
A. Arthur Sugerman, M.D. (Psychiat)
Stephen F. Wang, M.D. (Pediatr)
Edwin S. Wilson, M.D. (Radiol)
Louis S. Zeiger, M.D. (Nucl Med)
Robert B. Zufall, M.D. (Urol)

The Journal of the Medical Society of New Jersey (ISSN-0025-7524) is published monthly (since 1904) except semimonthly in July (13 issues), under direction of the Committee on Publication, by the Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648. Printed in East Stroudsburg, PA, by the Hughes Printing Co. Whole number of issues 961. Member's subscription ($10) is included in Society dues. Rates for nonmembers, $20; outside USA add $7.50 for postage. Single copies, $2. Address communications to *The Journal* MSNJ, Two Princess Road, Lawrenceville, NJ 08648, (609) 896-1766. Second-class postage paid at Trenton, NJ, and additional entry office.

Copyright 1984 by the Medical Society of New Jersey.

JMK

BMW

SAAB

Our reputation has been built on our SERVICE



JMK AUTO SALES

391 Rt. 22 (East) Springfield, New Jersey

379-7744

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

APRIL 1984

FEATURES

265 Membership Newsletter
276 Professional Liability Commentary
281 Editorial
283 Hospital Governing Boards
285 Physician Legal Bulletin

CONTRIBUTIONS

291 **Deaths Related to Narcotics Overdose in New Jersey**
E. Feuer, M.D., and J. French, M.A., Trenton
297 **Computerized Tomography-Guided Percutaneous Needle Biopsy**
K.L. Jewel, M.D., Montclair
303 **Premenstrual Syndrome: Fact or Fantasy?**
M.A. Pelosi, M.D., Bayonne
311 **Rehabilitation of Cognitive Function in Brain-Damaged Persons**
I.W. Pollack, M.D., H. Kohn, Ph.D., M.H. Miller, Ph.D., Piscataway
317 **Case Report: Tuberculous Abscess of the Spleen**
W.E. Farrer, M.D., and S. Ramamurti, M.D., Elizabeth
320 **Case Report: Intrauterine Testicular Torsion**
J. Rosenberg, M.D., and M. Zimmerman, M.D., Clifton
322 **Pharmacological Basis of Therapeutics: Anticonvulsant Agents**
H.M. Geller, Ph.D., Piscataway
325 **Pediatric Briefs**
R.H. Rapkin, M.D., F.C. Behrle, M.D., S.C. Sun, M.D., Newark

DOCTORS' NOTEBOOK

327 **Trustees' Minutes: February 19, 1984**
328 **President's Column,** Alexander D. Kovacs, M.D.
329 **UMDNJ Notes,** Stanley S. Bergen, Jr., M.D.
329 **MSNJ Auxiliary,** Mrs. Gale Wayman
330 **AMNJ Report,** Paul J. Hirsch, M.D.
330 **New Members**
331 **Dennis R. Filippone: Maimonides Award Recipient**
331 **Physicians Seeking Location in New Jersey**

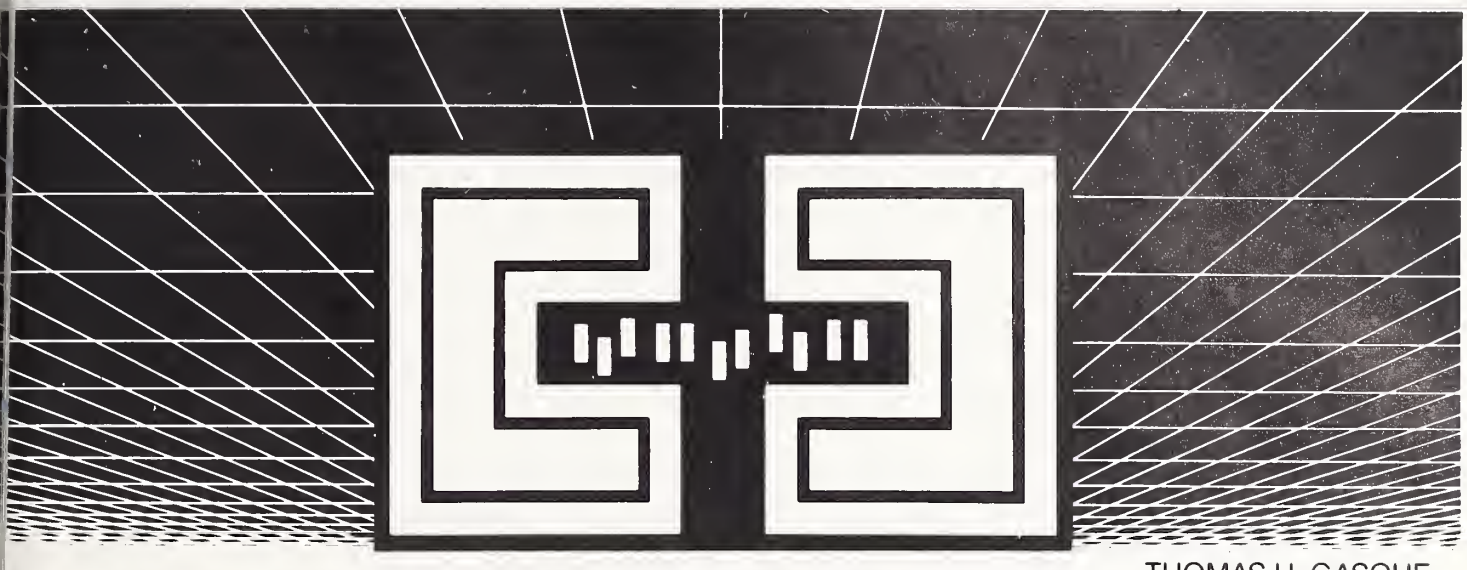
MSNJ DEPARTMENTS

335 Report of the Nominating Committee
337 CME Calendar
342 Letters to the Editor
344 Book Reviews
346 Obituaries
347 Information for Authors

On The Cover: Photographer and physician, Owen A. Shteir, M.D., a member of our Mercer County component, can be credited with this scene of Princeton farmlands. Dr. Shteir is an avid photographer whose work has been exhibited in the state.



Attention: DOCTORS*



THOMAS H. GASQUE
Producer

COMPUTER AND COMMUNICATION EXPO

convention hall, asbury park, new jersey

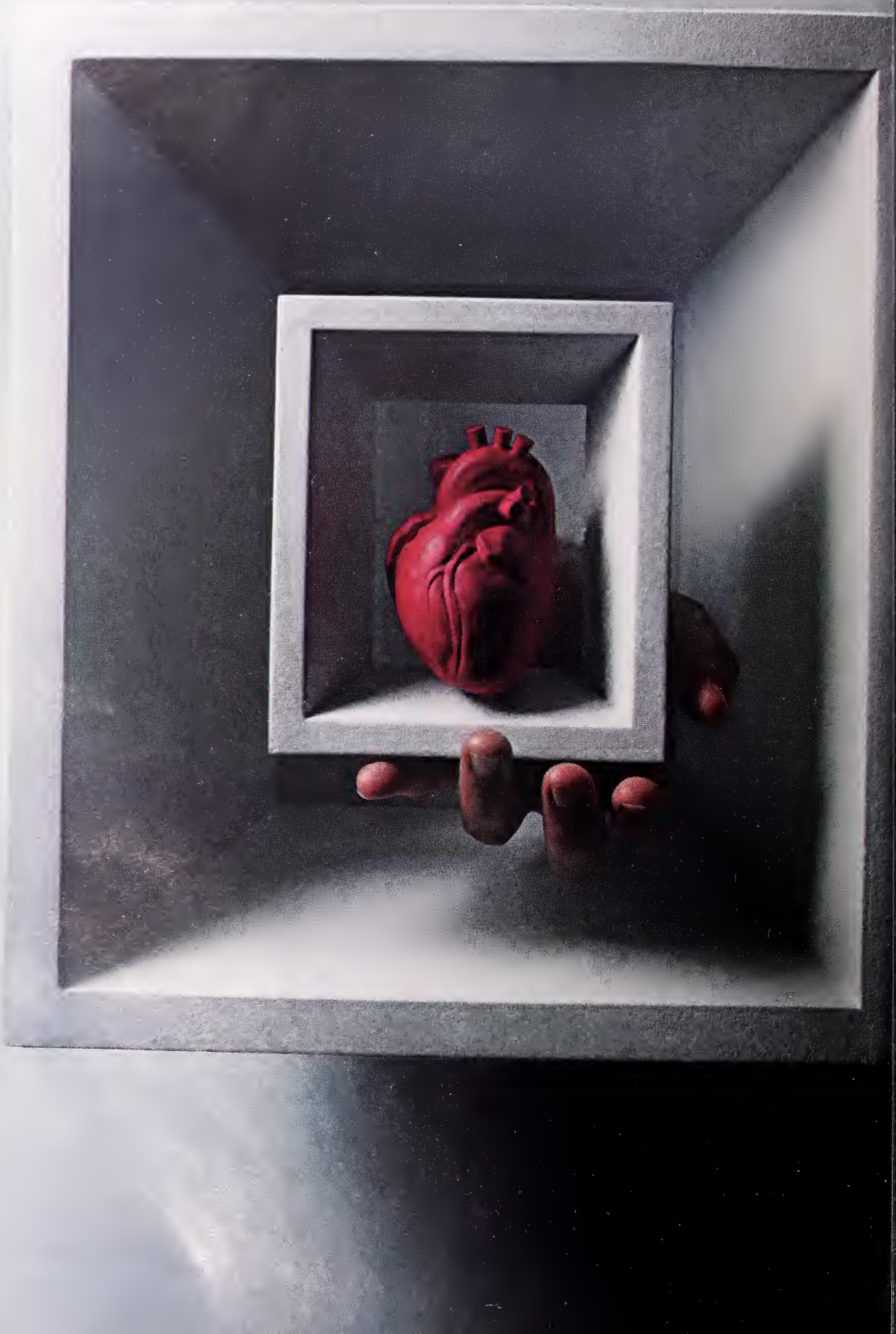
april 12·13·14·15, 1984 • 10am to 6pm daily

A Business Products/Services Exposition

* Special Seminars on
COMPUTERIZATION
for the Medical Profession
Hardware · Software · Consultation

Special Programs and Seminars scheduled for Corporate • Small Business • Banking Education • Legal Professions.

Computer and Communication Expo • Convention Hall, Asbury Park, N.J. 07712 • Tel. 201-776-6260



Angina Protection with Benefits for a Lifetime

ONCE-DAILY CONTROL WITH HEART-SAVING BENEFITS

By reducing heart rate and cardiac contractility, INDERAL LA helps protect the heart from the potentially serious and debilitating consequences of ischemia. A highly effective antianginal agent for around-the-clock control of symptoms, INDERAL LA also provides cardiovascular protection for a sense of security in the years ahead.

PROTECTION AND EXPERIENCE NO CALCIUM BLOCKER CAN MATCH

Unlike calcium blockers, INDERAL LA—either alone or with a nitrate—is recommended for early treatment of angina in the majority of patients. Equally important, INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use.

START WITH 80 MG ONCE DAILY

Dosage may be increased to 160 mg once daily, as needed, to achieve optimal control. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY **INDERAL LA** (PROPRANOLOL HCl) *LONG ACTING CAPSULES*



Ayerst®

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

JUST ONCE EACH DAY FOR SIMPLIFIED CORE THERAPY IN ANGINA

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease; elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

8833/384

Ayerst AYERST LABORATORIES
New York, N.Y. 10017

MEMBERSHIP NEWSLETTER

MSNJ

THE MEDICAL SOCIETY OF NEW JERSEY VOLUME 10

MANDATORY ASSIGNMENT—MEDICARE

HR-4170 still is pending in the U.S. Congress. It calls for a rollback of Medicare prevailing charges to the level set on June 30, 1983. This applies to physician services to Medicare hospital inpatients. Additionally, physicians would be required to accept Medicare assignment. Hospitals which do not have agreements with their medical staffs to accept assignments will be precluded from Part A-Hospital Reimbursement.

Regardless of the nature or extent of your Medicare practice the passage of HR-4170 will have a tremendous negative impact on you and your patients. Write your senators and representatives today. Ask your patients to write on their own behalf.

The Honorable Bill Bradley
United States Senate
Room 253
Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Frank R. Lautenberg
United States Senate
Room 717
Hart Senate Office Building
Washington, D.C. 20510

The Honorable James J. Florio
House of Representatives
Rayburn House Office Building
Room 2162
Washington, D.C. 20515

The Honorable William J. Hughes
House of Representatives
Cannon House Office Building
Room 341
Washington, D.C. 20515

The Honorable James J. Howard
House of Representatives
Rayburn House Office Building
Room 2245
Washington, D.C. 20515

The Honorable Chris Smith
House of Representatives
Cannon House Office Building
Room 422
Washington, D.C. 20515

The Honorable Marge Roukema
House of Representatives
Cannon House Office Building
Room 226
Washington, D.C. 20515

The Honorable Bernard J. Dwyer
House of Representatives
Cannon House Office Building
Room 404
Washington, D.C. 20515

The Honorable Matthew J. Rinaldo
House of Representatives
Rayburn House Office Building
Room 2338
Washington, D.C. 20515

The Honorable Robert A. Roe
House of Representatives
Rayburn House Office Building
Room 2243
Washington, D.C. 20515

The Honorable Robert G. Torricelli
House of Representatives
Cannon House Office Building
Room 317
Washington, D.C. 20515

The Honorable Peter W. Rodino, Jr.
House of Representatives
Rayburn House Office Building
Room 2462
Washington, D.C. 20515

The Honorable Joseph G. Minish
House of Representatives
Rayburn House Office Building
Room 2109
Washington, D.C. 20515

The Honorable James A. Courter
House of Representatives
Cannon House Office Building
Room 325
Washington, D.C. 20515

The Honorable Edwin B. Forsythe
House of Representatives
Rayburn House Office Building
Room 2210
Washington, D.C. 20515

The Honorable Frank J. Guarini
House of Representatives
Cannon House Office Building
Room 206
Washington, D.C. 20515

SERVICE FOR CRIME VICTIMS

Compensation for losses due to injuries is available to eligible victims of crime through the New Jersey Violent Crime Compensation Board. In the case of the death of the victim, payment may be ordered to or for the benefit of the dependents of the deceased victim. Persons who are injured while trying to prevent a crime or while assisting a police officer in making an arrest also may be eligible for compensation.

For more information, call 800-242-0804 or write to Commissioner Kenneth W. Welch, Chairman, Violent Crimes Compensation Board, 60 Park Place, Newark, NJ 07102.

MUTUAL PROTECTION ASSOCIATION

H.R. 2095 and H.R. 2486—Physicians' and Surgeons' Mutual Protection Associations. The AMA supported H.R. 2095 and H.R. 2486, bills that would provide tax-exempt status to physicians' and surgeons' mutual protection and indemnity associations providing professional liability coverage. The bills also provide that initial payments made by a physician to such entities would be tax deductible as a business expense. AMA commented that the bills represent a reasonable step towards providing equality of tax treatment for this form of providing essential professional liability coverage. (Letter, House Ways and Means Committee, January 6, 1984).

PREFERRED PROVIDER ORGANIZATIONS: LEGAL AND LEGISLATIVE ASPECTS*

It should be remembered that the Preferred Provider Organization (PPO) is an entrepreneurial marketing concept which seeks to achieve cost efficiencies in the delivery of health care through the use of legal contracting as a mechanism to encourage certain behavior patterns. Often, these are not legislated entities and the locus of their regulation is unclear. In addition, the application of the law to PPOs is as yet ambiguous since they are relatively new, and specific legislation is limited and judicial decisions are completely lacking. The following discussion, therefore, often deals with potential pitfalls rather than proven traps.

The regulation of the business of insurance, including health insurance, is an activity reserved for the states by Congress. All states have some sort of insurance code which provides for the regulation of insurance plans. Where legal barriers to PPO development exist on the state level, they usually involve the issue of whether or not it is legal in that particular state to restrict the insured's free choice of provider either by designating "preferred" providers or by creating financial or other incentives to choose designated providers. Many states have insurance code provisions guaranteeing the beneficiary or subscriber free choice of provider so long as the chosen provider is licensed to perform the particular service. Several of these states now are considering or implementing legislative changes which seek to control health care costs by creating competition among providers for patients and third-party reimbursement through the selective contracting mechanism.

It should be noted that self-insured employer groups and Taft-Hartley union trusts (prime marketing targets of many PPOs) are exempt from state insurance regulations by virtue of pre-emptive federal law. However, that federal law was amended in January 1983 to limit this exemption from state regulation for multiple employer trusts (METs). Whether and how the PPO concept can be incorporated into a third-party health insurance package, and to what extent it will be regulated, thus depends upon a particular state's insurance laws and regulations as well as the way in which the PPO is organized and marketed.

During the 1982 legislative session, the California legislature enacted three laws which greatly have affected the development of PPOs in that state. The first of these, AB 799, was enacted in response to a fiscal crisis in the state's Medicaid (Medi-Cal) program. This law authorizes Medi-Cal to negotiate selective and exclusive contracts with health care providers and delivery systems for the provision of health care services to Medi-Cal recipients. The Medi-Cal negotiators also were authorized to utilize a competitive bidding process in lieu of negotiations where it was deemed "expedient." In the case of hospital contracts for inpatient services, the negotiators were instructed to consider the total funds appropriated for inpatient services. AB 799 became effective July 1, 1982, for institutional providers, and on July 1, 1983, with respect to professional providers. Once contracts have been signed in an area, providers not under contract to the state will not be reimbursed for services delivered to Medi-Cal recipients, except for emergencies.

With the passage of AB 799, the insurance industry became concerned that this new infusion of competition into the Medi-Cal market would result in massive and unreasonable increased cost shifts to the private sector. As a consequence, AB 3480 was introduced and passed. The intent of this legislation was to provide that as of July 1, 1982: "An insurer may negotiate and enter into contracts for alternative rates of payment with institutional providers, and offer the benefit of such alternative rates to insureds who select such providers. Alternatively, insurers may, by agreement with group policyholders, limit payments under a policy to services secured by insureds from institutional providers, and after July 1, 1983, from professional providers, charging alternative rates pursuant to con-

*Reprinted with permission from the American Medical Association.

tract with such insurer." In other words, insurers and hospital service plans are not only permitted to contract selectively based on price with health care providers, they also may require their subscribers to utilize the contracting providers by limiting payment solely to those providers (the basis for Exclusive Provider Organizations or EPOs). Much of the impetus for EPOs provided by AB 3480 apparently has been blunted by a third piece of legislation, SB 2012. The overall effect of this third bill has been to tighten some of the provisions of AB 799 and AB 3480 by requiring ongoing professional peer review by "professionally recognized, unrelated third parties" of insurance companies' closed panel plans, and by prohibiting the conditioning of hospital medical staff privileges on a physician's willingness to contract with an insurer.

The overall effect of these three pieces of legislation in the state of California has been a dramatic increase in the level of interest and activity among hospitals, physicians, and insurers to develop Preferred Provider Organizations. Over 150 organizational entities have registered names with the California Department of Corporations. While many of these organizations may never achieve operational status, many others were ready to begin payment claims as of July 1, 1983, when the new laws took effect for professional providers. The impetus for these PPOs is cost containment and competition; to what extent they will meet these objectives is yet to be demonstrated.

While the marketing concept of preferred provider contracts or arrangements has arisen in several other states, the California statutes appear to be unique in their affirmative sanctioning of preferred provider contracts and exclusive provider arrangements. Using the California legislation as a model, however, several states are considering legislation which would remove the freedom of choice barrier to PPO development. In March 1983 the Virginia General Assembly passed a set of amendments (SB 110) to that state's insurance code. These amendments provide that: "One or more insurers may offer or administer a health benefit program under which insurer or insurers may offer preferred provider policies or contracts . . . which limit the numbers and types of health care services eligible for payment as preferred providers under such policies or contracts. Any such insurer or insurers shall establish terms and conditions which shall be met by a hospital, physician, or other provider . . . in order to qualify for payment as a preferred provider under such policies or contracts. These terms and conditions shall not discriminate unreasonably against or among such health care providers. No hospital, physician, or other provider . . . willing to meet the terms and conditions offered to it or him shall be excluded. Neither differences in prices among hospitals or other institutional providers produced by a process of individual negotiations with such providers or based on market conditions, nor price differences among providers in different geographical areas, shall be deemed unreasonable discrimination. Preferred provider policies or contracts offered pursuant to this section shall provide for payment for services rendered by nonpreferred providers, but such payments need not be the same as for preferred providers." Thus, the Virginia legislation paves the way for the establishment of Preferred Provider Organizations that utilize copayment incentives, but expressly prohibits the establishment of Exclusive Provider Organizations.

In 1982, the state of Arizona passed legislation to create the Arizona Health Care Cost Containment System (AHCCCS). This system is an experimental alternative to a traditional Medicaid program for Arizona; however, it permits Arizona to obtain federal Medicaid dollars. The overall goal of the AHCCCS plan is to develop and test an innovative payment and delivery system for providing health care services which facilitates cost containment while, at the same time, encouraging quality care in an efficient fashion. One of the unusual aspects of this program is that persons eligible to participate in the program will include not only the indigent and the medically needy, but also county, state, and private sector employees whose employer offers health care coverage through this system.

The AHCCCS model includes six major devices for containing costs: the creation of a network of primary care providers who will act as case managers in authorizing and supervising largely acute medical care to recipients; prepaid capitated contracts; competitive bidding for selective contracts; the use of nominal copayments; limited restrictions on choice of providers and primary care physicians; and capitated payment by HCFA to the state of Arizona.

Arizona has received a demonstration waiver from HCFA which includes provisions for cost-sharing requirements and for restrictions on free choice of provider. One interesting element of the Arizona system is that a statewide agency is responsible for contracting with providers at the county level to provide care for each county. The implementation of this program is divided into three stages: implementation first among the indigent and medically needy, second among state and local government employees, and lastly availability to private sector employers as one health insurance alternative. This program uses selective contracting and a PPO-type model as a mechanism to accomplish its cost-containment goals. Implementation of the program still is in a very early stage, so that no conclusions can be drawn regarding its cost effectiveness yet.

A 1983 Florida law authorizes and states that it shall not be construed as an unfair method of competition or an unfair or deceptive act or practice for commercial and not-for-profit insurers or groups of insurers providing individual health insurance or group, blanket or franchise health insurance to negotiate or enter into contracts with licensed health care providers for alternative rates of payment. Payments may be limited under a policy pursuant to agreement with insureds, to such alternative rates regardless of the provider chosen by the insured as long as the insurer offers the benefit of such alternative rates to insureds who select designated providers.

A 1983 Minnesota law states that it shall not be within the prohibition against discrimination and rebates for a commercial or not-for-profit insurer, in the case of a group health insurance policy, to pay differing amounts of reimbursement to insureds who elect to receive health care services from providers designated by the insurer. The insurer is required annually to file summary data regarding the financial reimbursement

offered to providers so designated and to disclose information regarding the name used to describe the special arrangement, the names of all providers designated by the insurer under the arrangement, and the terms of the agreements with designated health care providers.

The 1983 Wisconsin budget contains a section which becomes effective July 1, 1984, regarding PPOs. It provides that:

- A preferred provider plan is a health insurance contract which limits participation to providers selected by the health insurer; an open panel plan is a health insurance contract which does not limit participation except to providers who have agreed to participate in the plan and abide by its terms.
- PPOs may be established by an insurer or other person.
- Employers offering PPOs to their employees must also offer an open panel plan with substantially equivalent benefits. The employee must be given the opportunity to change plans once a year.
- No PPO may prevent any person from choosing among providers participating in the plan, except by requiring selection of primary providers when reasonably possible.

PPOs also must pay for services rendered by non-PPO providers who are willing to participate in the plan and abide by its terms. If such selection is made, the non-PPO provider is to be paid an amount he agrees to, but not more than would have been paid to a PPO provider. The plan may not require that payment to the non-PPO provider be less than what would be paid to a PPO provider.

- The PPO may require that a person who chooses non-PPO providers pay an amount up to $2,500 annually in addition to premiums and deductibles. (The Commissioner may set the figure lower.) Subject to this provision, the PPO may require a person to pay, in addition to any applicable deductible, up to 20 percent of payments to non-PPO hospitals.
- The Insurance Commissioner will issue administrative rules to ensure that patients need not travel excessive distances to receive their care from the PPO providers, and to ensure continuity of patient care.

Given the increasingly competitive nature of today's medical care marketplace, it seems reasonable to suppose that other states will follow the action already taken by states like California, Arizona, Virginia, Florida, Minnesota, and Wisconsin in creating a more permissive environment for selective contracting in both the public and private sector delivery of health care. At this writing, a bill is pending in Colorado and a proposal is expected to be introduced in Michigan during the next legislative session. Bills have been defeated in the states of Utah and Nevada.

On the federal level, a bill (HR 2956) was submitted to the House of Representatives in May 1983 by Congressman Wyden (D-Ore.) which, if passed, would supersede all "state insurance or other law or regulation" with regard to the negotiation of selective and exclusive contracts between "group health plan payors" and "providers of health care services." Representative Wyden's bill therefore would legalize the concepts of both a Preferred Provider Organization as well as an Exclusive Provider Organization.

The intent of this bill is to pre-empt state laws and regulations dealing with free choice of provider. Physicians, hospitals, and insurers interested in organizing or working with PPOs need to be wary of the possible antitrust implications of their activities, however, since this is an unsettled area of the law.

Since 1975, the U.S. Supreme Court increasingly has subjected the activities of the learned professions and their associations to scrutiny under the federal antitrust laws. These laws are intended to protect and foster market forces so as to insure free and open competition between and among sellers of goods and services. One of the difficulties inherent in applying the principles of antitrust law to health care is in the determination of what constitutes the necessary conditions of a state of workable competition. Since there has been so much regulation of the health care field over time, no one is certain what the "competitive solution" would look like. Philosophically, the concepts of antitrust and regulation are in diametric opposition to each other as ways to deal with market imperfections. Antitrust seeks basically to make the market work more efficiently, whereas regulation usually seeks to replace market forces in determining resource allocation.

Whenever there is collaboration or cooperation among natural competitors or individuals engaged in the same business, there exists a potential for antitrust implications. However, there are certain activities relating to health provider contracting which are more likely to create antitrust risk. These are: communications regarding prices, or exchanges of price or cost information from which it could be inferred that competing providers have agreed to affect prices charged to third-party payors; communications or coordinated conduct from which it could be inferred that competing providers have agreed not to compete as to particular service, geographic, or patient markets; agreements by competing providers to refuse to deal with particular third-party payors or to deal with them only on particular terms or conditions; agreements between one provider group (e.g. physicians) and a third-party payor which affect the terms or conditions upon which another provider group (e.g. chiropractors, clinical psychologists, or optometrists) may be compensated; the formation of entities (such as PPOs) for the purpose of dealing jointly with third-party payors; control of third-party payors by providers whose compensation is determined by the third-party payor; and provider peer review of utilization and fees charged by competitors.

The major antitrust statutes which are applicable to medical care delivery are: Sherman Antitrust Act: Section 1 of the Sherman Act prohibits contracts, agreements, combinations, or conspiracies in restraint of trade. This would include price-fixing, group boycotts, tying arrangements, division of markets, and customer allocation. Section 2 of the Sherman Act prohibits monopolization, conspiracies to monopolize, and certain attempts to monopolize. Federal Trade Commission Act: The Federal Trade Commission Act prohibits unfair methods of competition and unfair or deceptive acts or practices to consumers.

Other basic antitrust statutes are of less importance in the health care area. The Robinson-Patman Act

dealing with price discrimination, and Section 3 of the Clayton Act, which prohibits certain tying arrangements and exclusive dealing agreements, apply only to the sale of goods and commodities, not services. However, tying and exclusive dealing arrangements relating to services may be challenged as "unfair methods of competition" under the Federal Trade Commission Act. Furthermore, Section 7 of the Clayton Act prohibits acquisitions of corporate stock or assets that may result in the substantial lessening of competition or creation of a monopoly in any "line of commerce."

The most common charges to which PPOs may be subjected are price-fixing and restraint of trade. As noted earlier, agreements among competing providers which have the purpose or effect of raising, depressing, fixing, pegging, or stabilizing fees may be judged to constitute horizontal price-fixing—a per se violation of Section 1 of the Sherman Antitrust Act. A per se violation consists of conduct that has been determined to be unreasonably anticompetitive without regard to its business justification or actual effect on competitive conditions in individual cases. This rule has been asserted by the Federal Trade Commission to challenge the use of relative value scales (with or without agreement on a specific conversion factor) to determine fees. The same rule was applied by the U.S. Supreme Court in 1982 to prohibit the Maricopa Foundation for Medical Care's establishment of a maximum fee schedule. In this case, the Court rejected arguments of the provider members of the Foundation that their fee arrangement did not constitute per se horizontal price-fixing because the Foundation was analogous to a partnership or joint venture marketing a new or unique service. Concluding that the Foundation plan failed to satisfy the factual premises of such an argument—since the Foundation lacked the attributes of integration and risk-sharing found in the true joint venture, and offered no services different from those offered individually by its members—the Court expressed no opinion as to its validity.

By contrast, the lower courts consistently have upheld standard term reimbursement contracts (such as the physician participation contracts used by most Blue Cross/Blue Shield Plans), where they are entered into separately by third-party payors and individual providers. These courts have not considered the practice of limiting reimbursement in accordance with insurer-determined maximum fee schedules to constitute horizontal or vertical price-fixing—at least in the absence of evidence demonstrating provider control of the insurer's reimbursement policies.

Groups or organizations of independently practicing competing physicians that combine in a PPO arrangement to negotiate contracts or use relative value scales to determine fee schedules expose the PPO and its members to a significant risk of antitrust liability. PPO arrangements based upon reimbursement schedules determined by groups or entities independent of providers entail much less risk; especially if the contracting entity is free of any financial or controlling interests of hospitals, employers, or insurers participating in the plan, and negotiates bilateral contracts with individual providers, integrated group practices, professional partnerships, and institutions employing salaried staff. Antitrust risks increase as the PPO plan departs from such "brokerage" arrangements structured around an independent intermediary that determines reimbursement policies and maximum fee schedules, and negotiates contracts with payors and providers.

Alternatives to the "brokerage" type PPO plan include partnerships of physicians, and integrated joint ventures between hospitals or hospital groups and members of their medical staffs. Maricopa did not foreclose the possibility that such arrangements, if sufficiently integrated as a risk-bearing enterprise or organized to provide a unique form of service not otherwise available in the market, might escape per se condemnation as horizontal price-fixing combinations.

The rule of reason standards that may be applied to such PPOs cannot be predicted with precision. In balancing the competitive benefits and detriments of these integrated forms of practice, however, the collective market power of the participating providers will be considered one of the decisive measures of competitive impact. Authorities in antitrust law and economics differ with respect to the combined market share that might be indicative of a PPO's power to affect market prices or exclude competition. Partial integration of providers representing as little as 10 percent of market capacity may be considered anticompetitive in some cases, while a joint market share of 35 to 40 percent may be held insufficient to establish an unreasonable restraint of trade in others.

Market share also is regarded as a crucial determinant of legality under Section 2 of the Sherman Act. A PPO representing a predominant share (roughly 70 percent) of provider services in a distinct geographic market risks charges of monopolization. Lesser market shares may suffice to establish a dangerous probability of dominance required to sustain allegations of attempt to monopolize. Since many medical societies represent a significant portion of the physicians in their local markets, it may be unwise for them to organize PPOs, or serve as the locus for PPO information.

Another form of a per se violation of antitrust laws is the group boycott. If providers are permitted to form partnerships or joint ventures for the purpose of dealing collectively with private third-party payors, they still may incur boycott liability premised upon agreements not to deal with a particular person or entity. The most obvious source of boycott claims against provider-based PPOs would be other providers adversely affected by PPO determinations or policies—especially those providers initially denied access to, or dropped from PPO participation for failure to comply with quality or utilization criteria and policies, and those whose market base is eroded by the marketing efforts of the PPO. Boycott claims also may arise where a provider-sponsored PPO threatens or refuses to deal with a third-party payor seeking to affect its reimbursement policies or methods of fee determination. Such claims are more likely to be encountered, and to create a greater risk of liability, when the PPO represents a large share of the market, or its actions are undertaken with the purpose or effect of influencing the level of fees. To the extent that exclusion from the PPO denies a provider access to a resource essential to his competitive vitality, a finding of per se illegal horizontal boycott is more likely. Fee-related refusals

to deal raise serious risks of per se condemnation—either standing alone, or in conjunction with broader price-fixing allegations.

In many cases involving group boycott allegations, the courts apply a "rule of reason" standard rather than the per se rule. The rule of reason standard allows the defendants (the PPO and its members or sponsors) an opportunity to demonstrate that the procompetitive benefits of an arrangement outweigh any alleged anticompetitive effects. In other words, the PPO must be able to establish that the purpose and effect of its action was to enhance the quality of its services, thus increasing its own efficiency and competitiveness and that of the market as a whole.

As a final element of the discussion on PPOs and antitrust implications, it should be noted that there are circumstances under which immunity from antitrust scrutiny may be applicable. These include: State Action Exemption: Practices mandated and actively regulated by a state gain antitrust immunity. Examples of such practices may include those undertaken pursuant to certificate-of-need programs and state health planning; Noerr-Pennington Exception: This exception to applicability of the Sherman Act relates to activities genuinely undertaken to affect government policy, such as lobbying activities; McCarran-Ferguson Exemptions: This doctrine provides antitrust immunity to "the business of insurance," if state regulated. The Supreme Court, however, has stated that "the business of insurance is not the same as the business of insurance companies." The "business of insurance" involves the sharing of risk and is restricted to the relationship between the insurer and the insured.

While the exemptions from antitrust prosecution exist and may be found to be applicable to some situations, it remains to be tested whether some PPOs will be able to meet the criteria to qualify for such immunity.

In summary, antitrust questions and allegations may be raised whenever there is collaboration or cooperation among a group of competitors. The effect of such questioning, however, will depend upon how the PPO is organized, who negotiates what with whom, the size of the market share involved and whether the procompetitive effect of the arrangement outweighs the anticompetitive results. Moreover, not every constituted restraint of trade necessarily is prohibited, only those that are deemed by the courts to be unreasonable or to constitute per se violations.

The purpose of this section is to develop a framework for physicians to evaluate PPO contracting opportunities. The discussion will focus on a physician's perspective in responding to an organization which is sponsoring a PPO. An analysis is provided of factors which need to be evaluated in PPO contracting, implications involved in contracting for a physician's medical practice, and questions which should be raised in assessing a particular PPO proposal.

Once signed and agreed to, a contract is a legally binding document. It will be to a provider's advantage, therefore, to exercise a great deal of caution in evaluating contracts, negotiating terms, and understanding the legal obligations and implications created by such a contract. The physician should read the contract thoroughly, being careful to understand all of the language of the terms and obligations. It is advisable to obtain legal assistance in reviewing any such agreements prior to signing them.

Prudent business practice would seem to dictate that a physician contemplating a contract with an unfamiliar entity makes himself aware of the legitimacy and fiscal soundness of the organization offering the contract. Before entering into such a contract a physician should carefully research the contracting entity's financial track record and credibility. The veracity of information provided by the offeror of the contract should be checked. If, for example, physicians and hospitals are said to be enrolled, physicians should check to see that such contracts really do exist. Physicians also should make certain that all important details pertaining to the contract are committed to writing. Finally, physicians should obtain copies of and review the provisions of third-party/subscriber contracts which may control or affect provider relationships with PPO patients, other providers' hospitals, or the third-party payor or PPO.

One important issue in provider contracting relates to the level of risk to be assumed by each of the contracting parties; i.e. the potential financial loss or responsibility associated with performance under the terms of the contract. In evaluating the provisions of a preferred provider contract, physicians must be prepared to evaluate how much of this risk they are willing to assume as well as the costs associated with that risk.

General financial considerations which should be evaluated by physicians before entering into a selective provider contract include the following:

- Scope of Services: A clear definition of the scope of services covered by the contract is necessary in order to evaluate the level of risk associated with the provider's assumption of the contract. Clearly, the more vague the understanding with regard to scope of services to be provided, the higher the element of risk.
- Scope of Practice: In a similar vein, it will be important for physicians to evaluate carefully any clauses in the proffered contract which seek to define the scope of a physician's practice. Such clauses may include limitations on services which may be performed under the contract but for which the physician is otherwise qualified and licensed, limitations on which institutions the physician may use to hospitalize his patients, and limitations on physician referral patterns. The most extreme form of limitations on scope of practice would be illustrated by a contract which, when signed, prohibits the signatory physician from participating in any other contract agreements such as HMOs, IPAs, or other PPOs.
- Unit of Payment: The two most common alternative unit of payment systems for physician reimbursement are fee-for-service and capitation. Fee-for-service payment has the advantage to the physician of being virtually risk free. The physician is paid each time a unit of service is delivered. The disadvantages of this system to the payor are the lack of control and predictability with regard to price and the lack of built-in incentives for the provider to monitor utilization. Variations on the fee-for-service system include discounted charges and limitations on increases. All of the PPOs surveyed by the AMA pay physicians on a fee-for-ser-

vice basis. Capitation is a method of physician reimbursement based on the number of individuals enrolled instead of the number of services delivered. This is the physician reimbursement system commonly employed by Health Maintenance Organizations. The provider who signs a capitated contract usually assumes both the obligation to provide services for the fixed premium, and the financial risk for the cost of providing the service regardless of what is required. Ideally, physicians should build the cost associated with the assumption of this risk into their payment rate. A few PPOs are beginning to experiment with this type of payment system.

- Liability: Any clauses dealing with liability (either the physician's or the PPO's) should be examined very carefully. If the contract requires the physician to indemnify the carrier against liability (known as a "hold harmless" clause), most professional liability insurance policies do not provide coverage for contractually assumed liability. The physician might, therefore, be held personally liable for any damages against the insurer.
- Cost of Services: When negotiating a price for services under a contracting mechanism, each provider must attempt to compute the total cost of doing business as accurately as possible. Accurate historical and trend data will substantially enhance this portion of the negotiation process.

BRADLEY TO SPEAK AT JEMPAC FORUM

This year's JEMPAC Political Forum will have as its speaker Senator Bill Bradley. The Political Forum will be held on Friday, May 4, 1984, at the Annual Meeting in Atlantic City. A Wine and Cheese Reception for the Senator will follow his address. Invitations to JEMPAC members and those attending the Annual Meeting will be mailed shortly.

NJ MEMBERSHIP DRIVE

The facts are clear: in the space of little more than a year—December 1982 to present—JEMPAC has gained almost 200 memberships, a rate of growth unprecedented for the New Jersey group and for AMPAC member organizations this year generally. What is less obvious is how that kind of accomplishment is possible—or should we ask who?

Certainly the "who" in this case represents political action committee leadership, in the best sense of the word. And JEMPAC has found it in Dr. Peter Amirata, a general surgeon whose professional home is in Belleville and whose avocation is making physicians more responsive to the political process. Like many other physician-leaders—he was installed as President of the Essex County Medical Society in May of 1983—Dr. Amirata saw his organization's membership drive as a challenge and an opportunity. Just as importantly, he had the drive and imagination to make the most of it.

Amirata himself sees it more modestly. "It all began last May (1982) at the state medical society meeting in Trenton," he explains. "Dr. Kovacs, the incoming president, made a speech about how weak the organization was in terms of political donations and memberships. He asked everyone to seriously consider the importance of political action, and that started me thinking."

Amirata's first move was a daring one: "I was installed on May 12 as President of Essex County, and I asked Dr. Kovacs to be guest speaker. He said that the entire state of New Jersey had raised $14,000 in political contributions through physicians. Then I made my own pledge to him—that in one year, Essex County would be able to raise at least as much money as the entire state (JEMPAC) had."

The drive to fulfill the pledge began when Dr. Amirata marshalled a steering committee of physicians to help with publicity and promotion. JEMPAC next sent out letters to 1,500 physicians, largely through the efforts of Arthur Ellenberger, the Executive Secretary. ("I couldn't have done it without him," says Dr. Amirata). The letters were, of course, appeals for funds, but with a difference. Amirata made sure that an appropriate member of the committee had handwritten a personal note at the bottom of each ("how's your wife?") so that each physician contact saw the human connection with a known entity.

The approach, notes Amirata, has been used frequently in political campaigns, but is especially appropriate to physicians because "nurses usually open all incoming mail in the doctor's office, and will toss anything that looks like a form letter. They'll stop when they see a handwritten message."

The campaign—asking for $100 from each physician—generated an amazing 350 responses (compared to 10 to 15 responses from a similar effort initiated the year before). Some of the 1983 total came from telephone followups, as well as additional publicity in the Medical Society newsletter. As with any good direct mail effort, the campaign included a second mailing a month after the first. In all, the effort netted a healthy $17,000, as well as a surge in membership (almost 175 memberships have come in since July).

Having fulfilled his promise, Dr. Amirata sent a letter to Dr. Kovacs. He got in return a letter of acknowledgment, a position on the JEMPAC Board, and—he says—a great deal of personal satisfaction.

Dr. Amirata continues to encourage active political involvement from physicians, and practices what he preaches. He's been involved in several community and state campaigns; one of the most significant involved raising money for U.S. Congressman Bob Roe during his bid for the governorship of New Jersey. At the same time, the doctor can put political action in perspective. "I find that it really hasn't taken up too much of my time," he says. A principal interest now is the Clara Maass Professional Center in Belleville, where he is president of the medical clinic, as well as his active practice.

Does Amirata have any words for others who would like to duplicate his feat? "I can't stress enough that it's important for presidents of county medical societies to encourage the political involvement of doctors, and there are many ways to do it. Too many doctors are apathetic about politics, and there's no good reason for it. Whatever party they're in, whatever their political leanings, they've got to become more active, to make themselves heard as a profession.

Clearly, active involvement has been a benefit for Dr. Amirata—and for the Essex County Medical Society. AMPAC sends hearty congratulations to both. (*AMPAC Sustainer*, November 1983)

HOW NOT TO REFORM CAMPAIGNS

The following is reprinted from Congressman Jim Courter's *Washington Report:*

With congressional elections just months away, reform of the campaign process is likely to be one of the more prominent issues when Congress reconvenes. Over the years, there has been a tendency to equate financial contributions with political corruption. Since each election cycle generates more money than the preceding one, it is predictable that there are biannual cries that our legislators have become the puppets of large contributors and special interests, and that this money-based electoral system has reached the breaking point.

These charges are inaccurate, and they also may be quite dangerous. The public's confidence in its elected representatives is being threatened by the popular notion, reinforced by the media, that political "quid pro quos" are the norm. Those who see an evil connection between contributions and votes offer a proposal which, they claim, will sanitize the political process. Their solution: taxpayer-funded campaigns. While the specifics have varied over the years, all public financing schemes are based on two major assumptions. The first is that under the current campaign system, challengers cannot compete with the superior money-raising ability of incumbents. The second is that members of Congress are beholden to the special interests, like PACs, which have contributed to their candidacy.

Proponents of public financing wish to limit each candidate's spending, and to require that campaigns be funded, in whole or in part, by the government. They suggest that since all candidates would be spending aproximately the same amount, money no longer would be a factor and candidates would be examined on their own merits. Also, eliminating the opportunity for donations with "strings attached," would ensure that every legislator's actions mirror the views of the majority of his or her constituents, rather than reflecting a narrow interest with a big purse. Sound too good to be true? Well, it is.

First of all, a system of public financing which gives equal amounts to all candidates would have the unhealthy side effect of favoring the status quo. This is because the first task of any candidate is to become known and have his or her name recognized by the electorate. For the incumbent, this task largely is accomplished in the course of congressional duties through press coverage, correspondence with constituents, newsletters, and staff work. But the challenger, who lacks this advantage and the government funds which make it possible, must expend time and money just to establish an identity in the minds of the voters. Since the relative positions of incumbents and challengers are unequal, a seemingly evenhanded spending limit inherently is unfair, and would tend to preserve the incumbent by disarming the challenger.

The second reason given for public financing of congressional campaigns—to eliminate the influence of special interest PACs—misses the mark as well. One of the favorite arguments against PACs is that members of Congress court PAC representatives at the expense of everybody else. However, this ignores what PACs really are. Simply put, PACs are channels through which individuals can pool their resources in support of like-minded candidates.

PACs contributed less than 27 percent of all funds during the 1981 to 1982 midterm election. Critics point to this percentage as evidence of the "pernicious" influence of PACs. But, in fact, there is nothing "pernicious" about this statistic when it is realized that there are over 3,000 separate and often competing PACs giving an average of $500 per candidate. With many congressional campaigns costing $250,000 or more, one $1,000 PAC check, or even ten $1,000 PAC checks from the same industry are not likely to amount to an overwhelming corrupting influence on a Congressman. Too often, it is forgotten that a candidate's views are what attract contributions in the first place, and not the other way around. In other words, PACs donate to candidates who share their point of view.

Significantly, studies have shown the American public overwhelmingly opposes taxpayer-funded congressional elections. Quite naturally, the major reasons for this disapproval are that taxpayers don't want their money used to support candidates with whom they disagree, and that the government has better things to do than to build a welfare system for politicians. The most serious problem in our electoral system is voter apathy, not political corruption. Most people recognize that taxpayer-funded elections would exacerbate this apathy.

The high cost of campaigns, and the contributions which finance them, will continue to be singled out as targets for reform. But reformers who set out to slay the dragon of money in politics will find little evidence of the "pernicious" effects of it in the most expensive campaigns of 1982: Lew Lehrman's gubernatorial campaign in New York; Mark Dayton's race for the Senate; and Adam Levin's shot at a seat in the House. All three lost. What is most significant, however, is that with public financing, the biggest loser would have been the taxpayer.

MEDICAL ASSISTANTS' CONVENTION

The 21st Annual Convention of the American Association of Medical Assistants, state of New Jersey, Inc., will be held at the Cherry Hill Hyatt on April 26 to 29, 1984. For further information and registration contact Convention Chairman, Rosanne De Gennaro, CMA at 201-671-7029 (after 7 P.M.).

Highlights of education programs: nutrition, stress management, how computers will benefit a physician's office, anorexia, medical law and ethics, cyrosurgery, career opportunities, premenstrual syndrome, and blue shield/medicare/medicaid update.

FINI

It vexes people when a man is different from his neighbors and dares to be what they are not and never can be.

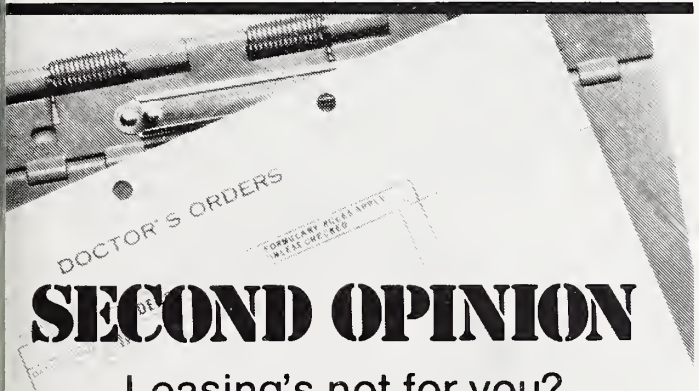
NEW YORK FERTILITY RESEARCH FOUNDATION, INC.

For the Investigation of
Problems of Human Infertility

The Foundation provides a complete diagnostic and consultation service for infertile couples. Investigations are conducted by well-known specialists in conjunction with consultants in the various fields of medicine related to infertility.

The Foundation is supported by an in-house modern laboratory equipped to do most tests required for diagnosis and treatment. Literature on request.

1430 Second Avenue, Suite 103
New York, N.Y. 10021
Phone: (212) 744-5500



SECOND OPINION

Leasing's not for you?

Compare these figures (based on a $20,000 vehicle):

DUE 1ST DAY	PURCHASE	LEASE*
6% sales tax	$1200	$25/mo.
down payment	4000	none
monthly payment	554	410
Total due:	$5754	$435

So by leasing, you've got $5319 savings on your initial outlay, plus $119 a month, to invest any way you'd like! And insurance is available to qualified N.J. motorists for as little as $600 a year. Call for similar savings on ANY make or model, foreign or domestic. *36-mo/closed-end

value lease inc

Evenings and weekends, call (201) 530-4088

Monmouth St., Red Bank, N.J. 07701 (201) 530-1282

If your professional liability insurance company ran out of money, you could find yourself very much . . .

. . . alone.

We're 6,900 New Jersey physicians insuring *ourselves* through our own non-profit company. If you haven't joined us, you could be more at risk than you know. You owe it to yourself — and those that depend on you — to call us for more information.

800-257-6288

Do it now. Everything is at stake.

A professional service message from the **Medical Inter-Insurance Exchange** of N.J.
Two Princess Road, Lawrenceville, NJ 08648
(609) 896-2404
*"The **Doctors'** Company"*

ANNUAL AWARDS DINNER

of

THE ACADEMY OF MEDICINE OF NEW JERSEY

Wednesday, May 23, 1984
6:00 P.M.

at
THE CHANTICLER
Short Hills, New Jersey

1984 AWARD RECIPIENTS

EDWARD J. ILL AWARD
ALFRED A. ALESSI, M.D.

CITIZENS AWARD
CONGRESSMAN JAMES COURTER
(R-12th District)

For further information, please contact:

The Academy of Medicine of New Jersey

EXECUTIVE OFFICES
The Academy of Medicine of New Jersey
Two Princess Road
Lawrenceville, NJ 08648
(609) 896-1717

WHY AMA?

Through the AMA library you can have immediate access to a vast store of medical, scientific, and socio-economic information. The library maintains a large collection of books, journals, and microfilm and provides instant on-line access to countless information sources through computerized data bases. The AMA library: it's one more good reason why you should be a part of the AMA.

To Join,
Contact your county or state medical society or write: Division of Membership, AMA, 535 North Dearborn Street, Chicago, Illinois 60610 or call collect, (312) 751-6196.

AMA AMERICAN MEDICAL ASSOCIATION

References:

1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PRDCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PRDCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PRDCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PRDCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PRDCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PRDCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PRDCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PRDCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PRDCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PRDCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PRDCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGDT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PRDCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PRDCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request

© 1982, Pfizer Inc.

Pfizer LABORATORIES DIVISION
PFIZER INC.

"I can do things that I couldn't do for 3 yrs. including joining the human race again."



Quotes from an unsolicited letter received by Pfizer from an angina patient.
While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

© 1983, Pfizer Inc.

"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

*Procardia is indicated for the management of
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA *brief summary on adjoining page.*

PROFESSIONAL LIABILITY COMMENTARY*

Physicians Need To Be Alert

Lawsuit Shield; Pharmacists Acting Like Doctors; Physician Owes Duty of Care in Employment Physical; Jack Anderson Takes Lawyers to Task

The idea came up over dinner last summer at her home in suburban Grosse Pointe Shores, Michigan, Yolanda Mascarin recalled. Why couldn't someone do something about the rising number of medical malpractice cases being filed against area physicians? That night, Mascarin, her husband, Telly, a doctor, their daughter Cathy, an anesthetist, and son-in-law Paul Huth, an attorney, discussed the problem. The conversation got Mascarin, who also is the mother of tennis pro Susie Mascarin, thinking and checking court files.

Recently, she went public with her plan: a new service in Wayne, Oakland, and Macomb Counties to let physicians know if their patients are "lawsuit-minded." The company, Physicians' Alert Inc., was announced in a mailing to 7,600 physicians in the tri-county area. Mascarin believes it is the first such business of its kind in the country.

The membership fee is $150 per doctor for 50 name checks over six months. Mascarin's staff of seven will check court records and let participating doctors know if their patients have initiated previous civil suits. If the doctors want more names checked in the six-month period, she charges an additional $2 per name. The mailing notice said that the new service would let doctors know that patients with a litigation history might be "a potential high risk" and "a stressful patient to accommodate." "Then the doctor can make his own assumptions about how to handle it," said Mascarin, whose husband's practice as an obstetrician-gynecologist puts him in the highest risk group for malpractice suits.

Mascarin, who is running the service out of her home with the aid of a computer, said she planned to expand the service within six months to oral surgeons, dentists, podiatrists, chiropractors, and others.

Huth, legal advisor to the new business, said doctors using the information provided by Physicians' Alert would have four choices: "One is not to see the patient two is to charge them more for the additional risk three is to (medically) chart them more carefully; or four, not to do anything other than be aware."

Huth says the new firm is simply distributing public information it feels may be useful. "Just because they're litigation-minded doesn't mean they would file malpractice suits. There seems to be a strong correlation, but we're not making that case," Huth said.

A spokesman for the Michigan State Medical Society said doctors using the service who refused to see certain patients would not be violating their code of ethics to provide medical care.

Mascarin said a study of every malpractice case filed in the tri-county area during a three-month period in 1982 revealed that 35 to 40 percent of the plaintiffs previously had filed civil suits.

Mascarin said these cases involved auto negligence personal injury, product liability, and property damages. Criminal, child custody, and divorce cases were not checked.

"We're looking for the nuisance suits, the things that should not have been filed. We're looking for the person who's looking for easy money, the person who lives off this kind of thing. If someone falls on someone's ice (and sues), that's what we're looking for. I think the doctors are anxious to get this help and find out who the nuisance patients are," Mascarin said.

Mascarin said she did not think a doctor using her service would refuse to see a patient just because that person had filed a product-liability suit. "I don't think they'll be scared off by one or two (cases). They'll be interested in the ones making a habit of it. This is public information, and all we're doing is making the doctor aware of it and he can handle it anyway he wants to," she said.

Mascarin said she hoped her new service also would help educate the public about how nuisance suits drive up the cost of medical care.

"It's just gotten way out of hand in Detroit. They make up ridiculous reasons to sue. It's three to four thousand dollars to settle many of these (nuisance suits), and people end up with that as spending money," she said.

Her husband blamed attorneys for much of the increase in malpractice suits: "All the advertising some attorneys are doing says, 'If we don't collect, you don't pay.' So what do people have to lose if all you have to do is file and know it won't go to court and you'll get something out of it."

Mascarin said his malpractice insurance costs him more than $20,000 a year.

Malpractice insurance coverage of a million dollars for other high-risk doctors like orthopedic surgeons

*This item from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse who are, respectively, Director of the Department and Director of Special Projects.

neurosurgeons, and heart specialists can cost between $25,000 and $33,000 a year, said one insurance executive.

"Maybe we should say (to patients): your office visit is $15 plus $3 for my malpractice insurance. It might bring it home to people," said Mascarin. (*Philadelphia Inquirer*, December 21, 1983)

THESE PHARMACISTS ARE ACTING MORE LIKE DOCTORS

Under a state grant, pharmacists in New Jersey are being trained to advise elderly patients on the proper use of medications. Pharmacists are sent to senior citizen centers and retirement communities to speak before groups or, more often, to provide one-to-one consultations. The program, which began in one county, has spread to 8 of the state's 21 counties. (*Medical Economics*, December 12, 1983)

MD OWES DUTY OF CARE IN EMPLOYMENT PHYSICAL

If a corporation engages a physician to examine a prospective employee, does the doctor owe a duty of care to the patient, even though there's been no prior relationship? Yes, says a California court of appeal.

A pilot applied to an airline for a job and was told he would be hired if he could pass a physical. The company sent him to a doctor who reported that he found a microaneurysm on the fundus of the eye. On that basis, the physician diagnosed the pilot's condition as prediabetic, which precluded his employment. The pilot sued the airline and the doctor.

A trial court entered a summary judgment against the pilot, and he appealed, reports *Medical Liability Advisory Service*. The appellate court was impressed by the medical evidence, which included reports from two other doctors who could find no aneurysm on the fundus, or any such predisposition to diabetes.

On the basis of other evidence, the court held that the pilot was "a very eligible candidate" for the job. The pilot said that as a result of the "negligent, careless, and reckless examination by the defendant," other airlines also had turned him away.

The airline and the doctor contended that neither owed the pilot a duty of care and that he should be required to show physical injury to be entitled to sue. This claim, the court said, was "meritless."

Reversing the judgment of dismissal, the court ruled that the doctor owed the pilot a duty to conduct and report the examination "with due care and to refrain from causing the appellant harm, whether physical or otherwise." The court said the defendants could have foreseen that "negligent determination or reporting" of the man's physical condition "could interfere with, and indeed destroy, his ability to pursue his flying career." (*Medical World News*, December 12, 1983)

ANDERSON TAKES LAWYERS TO TASK FOR WRONGDOING

Jack Anderson, the nationally syndicated columnist, has established as part of his column a section entitled, "Citizens' Watch." The idea is to have citizens report to Mr. Anderson instances of waste and wrongdoing which will help "to make democracy work."

In his column of January 4, 1984, "Citizens' Watch" took lawyers to task for activities which fall into the category of wrongdoing.

"Of all the complaints that flood into my office from my citizens' network, probably the most frequent have to do with lawyers.

"From Oklahoma City, Earl David Shaffer writes: 'A housecleaning of our court system is long overdue. American citizens are victimized by crooked lawyers who take advantage of their legal training to escape punishment.'

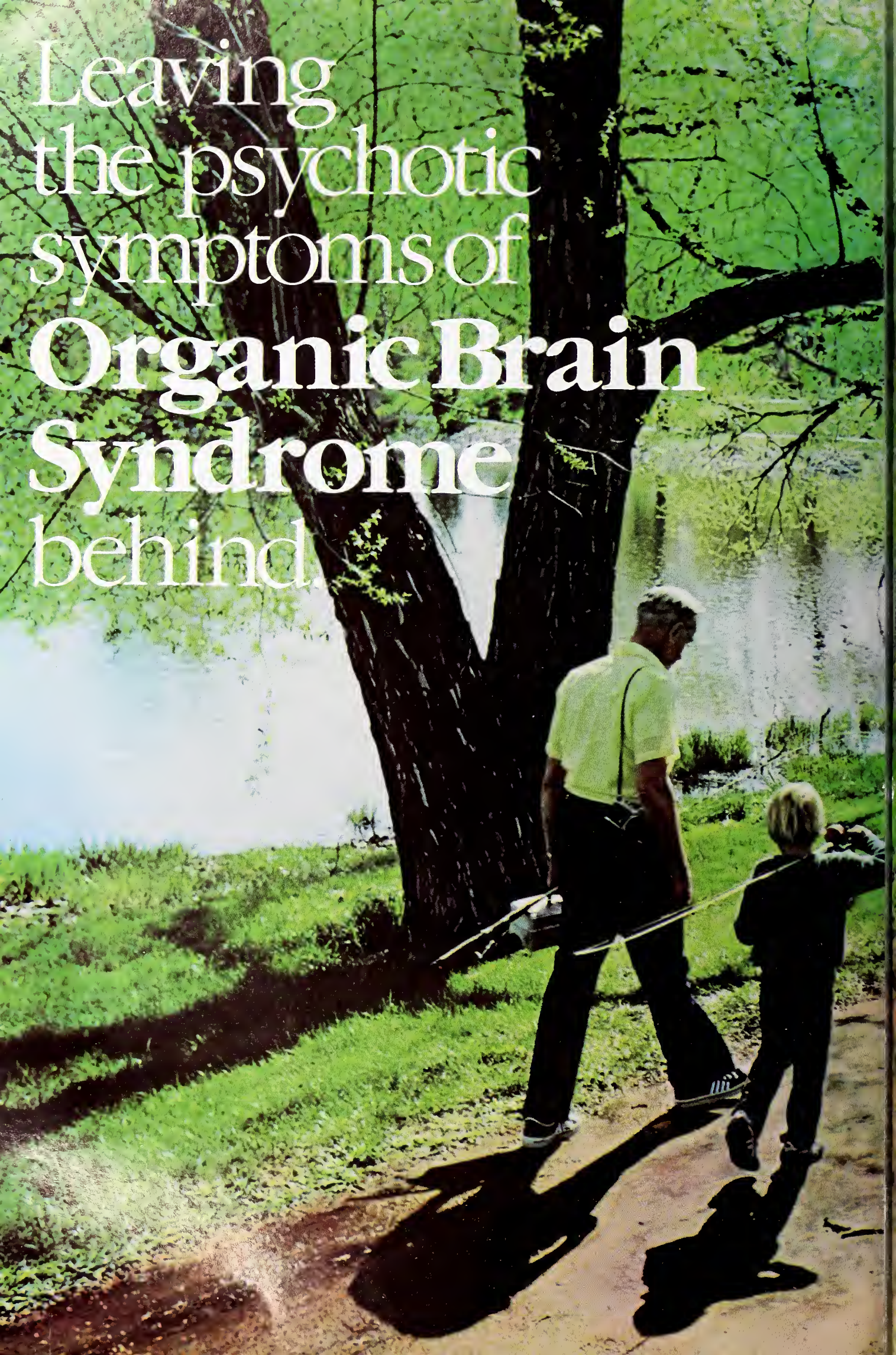
"From Seattle, Eric Peterson demands: 'Have you ever tried to file a grievance against an attorney? Forget it. The grievance committee will be made up of lawyers, who are more inclined to protect fellow lawyers than wronged clients. So what is left for you to do? File a malpractice suit? Forget it. The judges are also attorneys.'

"From San Diego, a private detective, who requests that his name be withheld, reports: 'California has been hit with an epidemic of lawsuits filed by ambulance-chasing lawyers who solicit business and offer to take their fees out of the judgments. The lawyers have little to lose: just the time it takes them to prepare the paperwork. But the victims are put through the anguish and expense of a costly legal defense. If the lawyers lose the gamble, they can write it off. The cost was nominal. But the victims are out thousands of dollars and many sleepless nights.'

"From Long Island, Joel Cohen writes: 'There is a new breed of vultures preying upon the American public. They're the attorneys who con their clients into believing they can get something for nothing by filing claims against doctors, hospitals, corporations, etc. Don't they know that the cost of defending and settling these lawsuits is passed on to the public? High-premium malpractice insurance has become part of every doctor's basic overhead. No wonder doctor bills are so high. Just about everyone doing business must retain a stable of lawyers. No wonder prices keep soaring. Litigation is one of the principal causes of inflation in this country.'

"From a suburb of Atlanta, J.M. Hall contends: 'Lawyers and judges will never clean up their own profession. You simply can't count on lawyers to discipline themselves. It will take legislation, a legal code of conduct, to bring lawyering under control in America.'" (*The Trentonian*, January 4, 1984)

Editorial Comment: We wait with interest to read what Mr. Anderson's readers have to say about physicians.


Leaving
the psychotic
symptoms of
Organic Brain
Syndrome
behind.



Effective

Treatment with Navane can produce improvement in psychotic symptoms such as hallucinatory behavior and unusual thought content as well as hostility, disorientation and depressive mood,[1,2] leaving the elderly patient more alert[2] and better able to participate in the activities of family life.

Well tolerated

Navane is generally well tolerated by elderly patients. Excessive sedation or drowsiness has been reported, but is uncommon.[1] Anticholinergic effects[3] and hypotension[4,5] are reported, but rarely. Should they occur, extrapyramidal symptoms can usually be readily controlled.

Navane®

(thiothixene) (thiothixene HCl)

Capsules 1 mg, 2 mg, 5 mg, 10 mg, 20 mg
Concentrate 5 mg/ml Intramuscular 2 mg/ml, 5 mg/ml

See following page for a brief summary of prescribing information.

© 1982, Pfizer Inc.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
at the forefront of psychopharmacology

Navane®
(thiothixene) (thiothixene HCl)

References. 1. Util TM, Unverdi C. Wohlrade J, et al: Drug therapy of psychosis associated with organic brain syndrome. Presented as a Scientific Exhibit at the American Public Health Association Centennial, Atlantic City, New Jersey, November 12-16. 1972. 2. Katz MM, Util TM: Video methodology for research in psychopathology and psychopharmacology. *Arch Gen Psychiatry* 31:204-210, 1974. 3. Ketai R: Psychotropic drugs in the management of psychiatric emergencies. *Postgraduate Medicine* 58:87-93, 1975. 4. Birkett DP, Hirschfield W, Simpson GM: Thiothixene in the treatment of diseases of the senium. *Curr Ther Res* 14:775-779, 1972. 5. Data on file at Roerig.

BRIEF SUMMARY OF PRESCRIBING INFORMATION
Navane® (thiothixene) Capsules: 1 mg, 2 mg, 5 mg, 10 mg, 20 mg
(thiothixene hydrochloride) Concentrate: 5 mg/ml, Intramuscular: 2 mg/ml, 5 mg/ml
Contraindications: Navane (thiothixene) is contraindicated in patients with circulatory collapse, comatose states, central nervous system depression due to any cause, and blood dyscrasias. Navane is contraindicated in individuals who have shown hypersensitivity to the drug. It is not known whether there is a cross-sensitivity between the thioxanthenes and the phenothiazine derivatives, but the possibility should be considered.
Warnings: *Usage in Pregnancy*—Safe use of Navane during pregnancy has not been established Therefore, this drug should be given to pregnant patients only when, in the judgment of the physician, the expected benefits from the treatment exceed the possible risks to mother and fetus. Animal reproduction studies and clinical experience to date have not demonstrated any teratogenic effects.

In the animal reproduction studies with Navane, there was some decrease in conception rate and litter size, and an increase in resorption rate in rats and rabbits, changes which have been similarly reported with other psychotropic agents. After repeated oral administration of Navane to rats (5 to 15 mg/kg/day), rabbits (3 to 50 mg/kg/day), and monkeys (1 to 3 mg/kg/day) before and during gestation, no teratogenic effects were seen. (See Precautions.)

Usage in Children—The use of Navane in children under 12 years of age is not recommended because safety and efficacy in the pediatric age group have not been established.

As is true with many CNS drugs, Navane may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery, especially during the first few days of therapy Therefore, the patient should be cautioned accordingly.

As in the case of other CNS-acting drugs, patients receiving Navane should be cautioned about the possible additive effects (which may include hypotension) with CNS depressants and with alcohol.
Precautions: An antiemetic effect was observed in animal studies with Navane, since this effect may also occur in man, it is possible that Navane may mask signs of overdosage of toxic drugs and may obscure conditions such as intestinal obstruction and brain tumor.

In consideration of the known capability of Navane and certain other psychotropic drugs to precipitate convulsions, extreme caution should be used in patients with a history of convulsive disorders or those in a state of alcohol withdrawal since it may lower the convulsive threshold. Although Navane potentiates the actions of the barbiturates, the dosage of the anticonvulsant therapy should not be reduced when Navane is administered concurrently.

Caution as well as careful adjustment of the dosage is indicated when Navane is used in conjunction with other CNS depressants other than anticonvulsant drugs.

Though exhibiting rather weak anticholinergic properties, Navane should be used with caution in patients who are known or suspected to have glaucoma, or who might be exposed to extreme heat, or who are receiving atropine or related drugs.

Use with caution in patients with cardiovascular disease.

Also, careful observation should be made for pigmentary retinopathy, and lenticular pigmentation (fine lenticular pigmentation has been noted in a small number of patients treated with Navane for prolonged periods). Blood dyscrasias (agranulocytosis, pancytopenia, thrombocytopenic purpura), and liver damage (jaundice, biliary stasis) have been reported with related drugs.

Undue exposure to sunlight should be avoided. Photosensitive reactions have been reported in patients on Navane.

Neuroleptic drugs elevate prolactin levels; the elevation persists during chronic administration. Tissue culture experiments indicate that approximately one-third of human breast cancers are prolactin dependent *in vitro*, a factor of potential importance if the prescription of these drugs is contemplated in a patient with a previously detected breast cancer. Although disturbances such as galactorrhea, amenorrhea, gynecomastia, and impotence have been reported, the clinical significance of elevated serum prolactin levels is unknown for most patients. An increase in mammary neoplasms has been found in rodents after chronic administration of neuroleptic drugs. Neither clinical studies nor epidemiologic studies conducted to date, however, have shown an association between chronic administration of these drugs and mammary tumorigenesis; the available evidence is considered too limited to be conclusive at this time.

Intramuscular Administration—As with all intramuscular preparations, Navane Intramuscular should be injected well within the body of a relatively large muscle. The preferred sites are the upper outer quadrant of the buttock (i.e. gluteus maximus) and the mid-lateral thigh.

The deltoid area should be used only if well developed, such as in certain adults and older children, and then only with caution to avoid radial nerve injury. Intramuscular injections should not be made into the lower and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.
Adverse Reactions: *Note:* Not all of the following adverse reactions have been reported with Navane (thiothixene). However, since Navane has certain chemical and pharmacologic similarities to the phenothiazines, all of the known side effects and toxicity associated with phenothiazine therapy should be borne in mind when Navane is used.

Cardiovascular effects: Tachycardia, hypotension, lightheadedness, and syncope. In the event hypotension occurs, epinephrine should not be used as a pressor agent since a paradoxical further lowering of blood pressure may result. Nonspecific EKG changes have been observed in some patients receiving Navane. These changes are usually reversible and frequently disappear on continued Navane therapy. The incidence of these changes is lower than that observed with some phenothiazines. The clinical significance of these changes is not known.

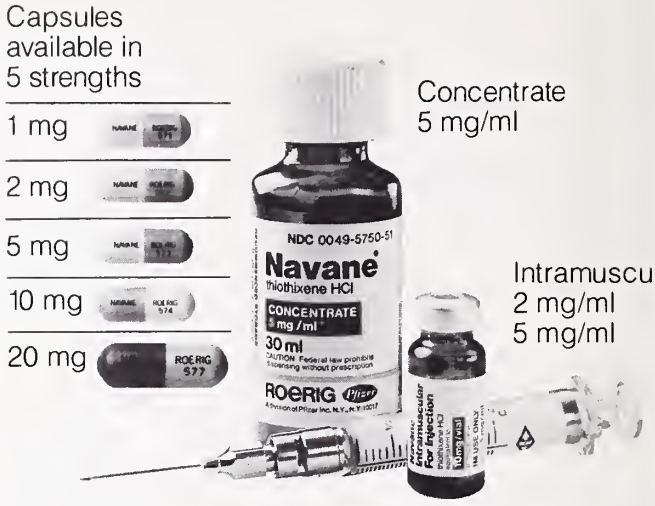
CNS effects: Drowsiness, usually mild, may occur although it usually subsides with continuation of Navane therapy. The incidence of sedation appears similar to that of the piperazine group of phenothiazines, but less than that of certain aliphatic phenothiazines. Restlessness, agitation and insomnia have been noted with Navane (thiothixene). Seizures and paradoxical exacerbation of psychotic symptoms have occurred with Navane infrequently

Hyperreflexia has been reported in infants delivered from mothers having received structurally related drugs.

In addition, phenothiazine derivatives have been associated with cerebral edema and cerebrospinal fluid abnormalities.

Extrapyramidal symptoms such as pseudo-parkinsonism, akathisia, and dystonia have been reported Management of these extrapyramidal symptoms depends upon the type and severity. Rapid relief of acute symptoms may require the use of an injectable antiparkinson agent. More slowly emerging symptoms may be managed by reducing the dosage of Navane and/or administering an oral antiparkinson agent.

Persistent Tardive Dyskinesia: As with all antipsychotic agents tardive dyskinesia may appear in some patients on long term therapy or may occur after drug therapy has been discontinued. The risk seems to be greater in elderly patients on high-dose therapy, especially females. The symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Sometimes these may be accompanied by involuntary movements of extremities.



There is no known effective treatment for tardive dyskinesia; antiparkinsonism agents usually d not alleviate the symptoms of this syndrome. It is suggested that all antipsychotic agents b discontinued if these symptoms appear.

Should it be necessary to reinstitute treatment, or increase the dosage of the agent, or switch to different antipsychotic agent, the syndrome may be masked.

It has been reported that fine vermicular movements of the tongue may be an early sign of th syndrome and if the medication is stopped at that time, the syndrome may not develop.

Hepatic effects: Elevations of serum transaminase and alkaline phosphatase, usually transien have been infrequently observed in some patients. No clinically confirmed cases of jaundic attributable to Navane (thiothixene) have been reported.

Hematologic effects: As is true with certain other psychotropic drugs, leukopenia ar leukocytosis, which are usually transient, can occur occasionally with Navane. Other antipsychot drugs have been associated with agranulocytosis, eosinophilia, hemolytic anemia, thror bocytopenia and pancytopenia.

Allergic reactions: Rash, pruritus, urticaria, photosensitivity and rare cases of anaphylaxis ha been reported with Navane. Undue exposure to sunlight should be avoided. Although not expe enced with Navane, exfoliative dermatitis and contact dermatitis (in nursing personnel) have bee reported with certain phenothiazines.

Endocrine disorders: Lactation, moderate breast enlargement and amenorrhea have occurre in a small percentage of females receiving Navane. If persistent, this may necessitate a reductio in dosage or the discontinuation of therapy. Phenothiazines have been associated with fals positive pregnancy tests, gynecomastia, hypoglycemia, hyperglycemia, and glycosuria.

Autonomic effects: Dry mouth, blurred vision, nasal congestion, constipation, increased swea ing, increased salivation, and impotence have occurred infrequently with Navane therap Phenothiazines have been associated with miosis, mydriasis, and adynamic ileus.

Other adverse reactions: Hyperpyrexia, anorexia, nausea, vomiting, diarrhea, increase in appe tite and weight, weakness or fatigue, polydipsia and peripheral edema.

Although not reported with Navane, evidence indicates there is a relationship betwee phenothiazine therapy and the occurrence of a systemic lupus erythematosus-like syndrome.

NOTE: Sudden deaths have occasionally been reported in patients who have received certa phenothiazine derivatives. In some cases the cause of death was apparently cardiac arrest asphyxia due to failure of the cough reflex. In others, the cause could not be determined nor cou it be established that death was due to phenothiazine administration.
Dosage and Administration: Dosage of Navane should be individually adjusted depending on th chronicity and severity of the condition. In general, small doses should be used initially an gradually increased to the optimal effective level, based on patient response.

Some patients have been successfully maintained on once-a-day Navane therapy.

Usage in children under 12 years of age is not recommended because safe conditions for its us have not been established.

Navane Intramuscular Solution: Navane For Injection—Where more rapid control and treatmen of acute behavior is desirable, the intramuscular form of Navane may be indicated. It is also benefit where the very nature of the patient's symptomatology, whether acute or chronic, render oral administration impractical or even impossible.

For treatment of acute symptomatology or in patients unable or unwilling to take oral medicatio the usual dose is 4 mg of Navane Intramuscular administered 2 to 4 times daily. Dosage may b increased or decreased depending on response. Most patients are controlled on a total dai dosage of 16 to 20 mg The maximum recommended dosage is 30 mg/day. An oral form shoul supplant the injectable form as soon as possible. It may be necessary to adjust the dosage whe changing from the intramuscular to oral dosage forms. Dosage recommendations for Navan (thiothixene) Capsules and Concentrate appear in the following paragraphs.

Navane Capsules; Navane Concentrate—In milder conditions, an initial dose of 2 mg three time daily. If indicated, a subsequent increase to 15 mg/day total daily dose is often effective.

In more severe conditions, an initial dose of 5 mg twice daily.

The usual optimal dose is 20 to 30 mg daily. If indicated, an increase to 60 mg/day total dail dose is often effective. Exceeding a total daily dose of 60 mg rarely increases the beneficia response.
Overdosage: Manifestations include muscular twitching, drowsiness, and dizziness. Symptoms gross overdosage may include CNS depression, rigidity, weakness, torticollis, tremor, salivatior dysphagia, hypotension, disturbances of gait, or coma.

Treatment: Essentially is symptomatic and supportive. For Navane oral, early gastric lavage i helpful. For Navane oral and Intramuscular, keep patient under careful observation and maintai an open airway, since involvement of the extrapyramidal system may produce dysphagia an respiratory difficulty in severe overdosage. If hypotension occurs, the standard measures fo managing circulatory shock should be used (I.V. fluids and/or vasoconstrictors.)

If a vasoconstrictor is needed, levarterenol and phenylephrine are the most suitable drugs Other pressor agents, including epinephrine, are not recommended, since phenothiazine derivatives may reverse the usual pressor action of these agents and cause further lowering of the bloo pressure.

If CNS depression is present and specific therapy is indicated, recommended stimulant include amphetamine, dextroamphetamine, or caffeine and sodium benzoate. Stimulants tha may cause convulsions (e.g picrotoxin or pentylenetetrazol) should be avoided Extrapyramida symptoms may be treated with antiparkinson drugs.

There are no data on the use of peritoneal or hemodialysis, but they are known to be of little valu in phenothiazine intoxication.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals

EDITORIAL

Preventing Death from "Hits"

A. ARTHUR SUGERMAN, M.D.

The report on deaths related to the use of heroin, methadone, and "hits" in New Jersey in 1980 and 1981 is reported. The ingredients of "hits" come from prescriptions, and the author urges control in prescribing these drugs.

On page 291, Feuer and French report on deaths related to the use of heroin, methadone, and "hits" in New Jersey during 1980 and 1981. Overdoses of heroin account for 126 deaths, methadone for 46, and "hits" for 36, while another 19 were due to mixtures, of which 9 were of "hits" and other drugs. The average age of the 31 males and 5 females who died of "hits" overdose was 22.

This dangerous poison which almost always is taken orally is a combination of two medications only too easily obtained by prescription: codeine, usually combined in 1 grain dose with 5 grains of aspirin or acetaminophen (Empirin® with codeine, Empracet® with codeine, A.P.C. with codeine, and many other proprietary and generic preparations), and Doriden® (glutethimide), a widely used but also widely abused hypnotic which can produce physical and psychological dependence.

Although codeine is an opiate, it is a very safe narcotic when used in therapeutic amounts and very rarely is used as the drug of first choice by addicts. However, when heroin and other preferred opiates become temporarily unavailable, codeine is used as a readily available substitute. Doriden® may be lethal in doses as low as 5 gm but the usual acute lethal dose is 10 gm to 20 gm. The chronically dependent user of Doriden® is in great danger if its use is discontinued abruptly, as withdrawal symptoms may include grand mal seizures.

In California, the combination of Doriden® and codeine #4 is known as "loads" or "dors and fours" and Cohen states that the use of this combination in southern California was responsible for two-thirds of the nation's codeine-related deaths during 1981.[1] Cohen suggests that the switch to such oral combinations is due to the poor quality of currently available street heroin. However, Feuer and French provide evidence that the users of "hits" are very seldom heroin users, and are unlikely to show evidence of any intravenous use of drugs. They are younger, less experienced, and probably nonaddicted; they take "hits" orally as a convenient way of obtaining a high like that of heroin.

As physicians, we can do little to control the use of street heroin, but the ingredients of "hits" come entirely from physicians' prescriptions. Deaths from "hits" were reduced sharply in California by prosecuting private physicians and "stress clinics" who were prescribing large amounts of these drugs. If we must prescribe hypnotics, there are several benzodiazepines which are much safer than Doriden®. We should prescribe analgesics in necessary quantities only, and avoid codeine if aspirin or acetaminophen alone is enough. This is a simple way to save 30 to 40 or more lives a year in New Jersey.

REFERENCE

1. Cohen S: Codeine use and abuse. *Drug Abuse and Alcoholism Newsletter* XI

MEDICAL COMPUTERS
DEC - IBM - TELEVIDEO

THINKING OF COMPUTERIZING YOUR PRACTICE?
FBL MEDICAL COMPUTER SPECIALISTS offers a wide variety of hardware/software configurations for every medical office size and application.

- AUTOMATIC INSURANCE FORM PREPARATION
- ACCOUNTS RECEIVABLE CONTROL
- AUTOMATIC PATIENT RECALL
- PRACTICE MANAGEMENT REPORTS
- CLINICAL RECORDS
- APPOINTMENT SCHEDULING
- ELECTRONIC CLAIMS SUBMISSION
- WORD PROCESSING
- MEDICARE/MEDICAID BILLING
- GENERAL LEDGER

FREE OFFICE ANALYSIS AND CONSULTATION — NO OBLIGATION

FBL

PROVIDING YOU WITH OVER 15 YEARS OF MEDICAL COMPUTER EXPERIENCE

3 ROUTE 46W, FAIRFIELD, N.J. 07006 201-882-9210

TAX SHELTERS

Just one of the personal financial services available to you from the ***physician's bank.***

Personal Counseling:
- new sites for practice
- increase practice size
- new accounting methods
- money management
- cash flow • investments
- tax planning
- estate planning

Call or Write
Joseph J. Verbaro, Jr.
Senior Vice President
(201) 228-9770

FINTRUST
FINANCIAL AND TRUST SERVICES
DIVISION OF SECURITY NATIONAL BANK & TRUST COMPANY OF NEW JERSEY
101 Eisenhower Parkway
Roseland, New Jersey 07068 Member F.D.I.C.

Doctors: Write your own prescription to cure insurance pains . . .

℞ Prescription

Name MSNJ Member

MSNJ Group
Blue Cross/Blue Shield
Major Medical and
Dental Insurance

that provides:
- **Flexible plans**
- **Comprehensive benefits**
- **Low, competitive rates**
- **Centralized Administration**

Designed and Administered by
DONALD F. SMITH & ASSOCIATES

℞ Prescription

Name _____

Address _____

Phone _____

Please send more information on the MSNJ

☐ Blue Cross/Blue Shield Program
☐ Major Medical Program
☐ Group Dental Program

Return to:
Donald F. Smith & Associates
One Airport Place, Route 206 North
P.O. Box 2197,
Princeton, New Jersey 08540
(609) 924-8700, (201) 622-6046

Medical Staff Participation on the Hospital Governing Board

VINCENT A. MARESSA, J.D.

To assist these governing board members in evaluating the quality of care, the board should be composed of three to five attending medical staff members and programs should be presented to the governing board acquainting them with medical and patient care issues.

Hospital governing boards are responsible for the quality of care rendered in their institutions. When the quality of care provided by physicians is reviewed, that review is conducted almost exclusively by the medical staff subject to final action of the governing board.

New Jersey presents an additional component of review in that PSROs conduct physician reviews on patients insured by both federal and nonfederal programs because of the DRG program.

Not infrequently, the decision rendered by a hospital review committee conflicts with a review conducted by a PSRO on the care rendered to the same patient. Since Medicaid will not recognize internal review, but requires the use of external review organizations, the potential for differing decisions is magnified.

The hospital governing board, therefore, may find itself in a position of having to evaluate several reports from different sources on the same issue.

Governing board members must balance consistently their loyalty to the hospital, its patients, and the community served by the hospital. Sometimes persons appointed to hospital governing boards are not familiar with the operation and administration of hospitals, the practice of medicine, and the provision of other types of health care services. They rarely talk, if ever, to physicians on the medical staff. Consequently, they may have no appreciation of all the complex and far-reaching issues they are deciding.

There are two steps we suggest to meet the issue of assisting a governing board in evaluating the quality of care rendered in their hospital.

The medical staff of each hospital is an extremely valuable asset that has been underutilized. Every hospital governing board should have three to five members of the attending medical staff, elected by the medical staff, to serve as members of the governing board.

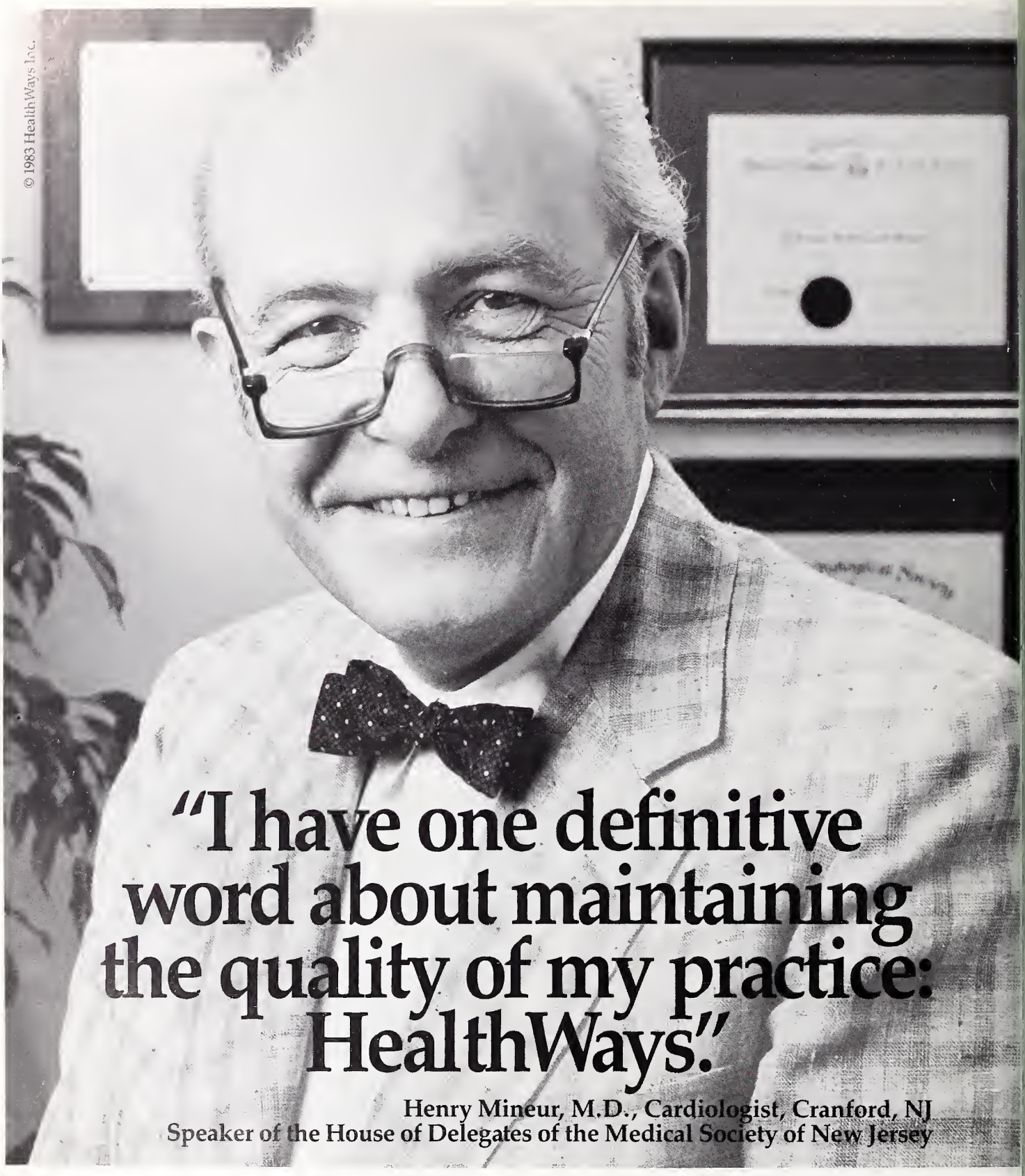
Programs should be presented by the medical staff to the governing board to acquaint them with medical and patient care issues. These could be structured to take no more than one hour and could be presented on a bi-meeting basis.

The perspective of the medical staff is vital to the function of the hospital.

Economic pressures on hospitals are increasing. It is currently stated that 40 New Jersey hospitals had negative operating results in 1982. While bottom-line orientation has desirable effects it also has the potential of adversely impacting the quality of care. Trustees can assure themselves of circumstantial guarantees of adequate judgment on quality issues by providing for significant input from and discussions with their medical staff.

*The material for this column is coedited by Arthur Krosnick, M.D., Editor, *The Journal*, MSNJ; Vincent A. Maressa, M.D., Executive Director, MSNJ; and James E. George, M.D., J.D., Director of Professional Liability, MSNJ.

© 1983 HealthWays Inc.



"I have one definitive word about maintaining the quality of my practice: HealthWays."

Henry Mineur, M.D., Cardiologist, Cranford, NJ
Speaker of the House of Delegates of the Medical Society of New Jersey

"Sadly, as the cost of medical care increases and the scope of many health insurance programs decreases, my patients wind up in a terrible squeeze. I found a very satisfactory solution. I became a participating physician in HealthWays.

With HealthWays, I can practice the kind of medicine that will truly benefit my patients without worrying about their financial positions because of the HealthWays unique physician reimbursement policy. That's a significant plus.

In addition, the administrative and financial structure of HealthWays is fighting the astonishing escalation of costs by covering procedures easily done on an out-patient basis rather than in the hospital. That makes a lot of sense. So does their policy of covering routine check-ups. And since the bills go directly to HealthWays, the specter of unpaid bills is eliminated."

HealthWays can be most valuable to your practice too. For more information, call Jon Marsicano, M.D., Vice President, Medical Affairs, at 201-636-6200 or 609-394-1995.

HealthWays
THE WAY TO BETTER HEALTH CARE.

PHYSICIAN LEGAL BULLETIN

MSNJ

THE MEDICAL SOCIETY OF NEW JERSEY VOLUME 3

PROFESSIONAL LIABILITY AND THE ANESTHESIOLOGIST

JAMES E. GEORGE, M.D., J.D., AND MADELYN S. QUATTRONE, J.D.*

Of all medical specialties, anesthesiology perhaps has the highest potential for severe adverse conseqences to the patient. When something goes wrong during the administration of anesthesia, the consequences may be death, coma, or vegetative states. These consequences are tragic for the patients and families involved. The severity and permanency of some anesthesia occurrences are an important reason why patients' families are most unwilling to accept a mysterious explanation for why their loved one did not come out of anesthesia satisfactorily. While not every anesthesia occurrence can be equated with negligence, the tragic consequences of anesthesia mishaps often result in a lawsuit.

This issue of the *Physician Legal Bulletin* focuses on the problems of professional liability for anesthesia mishaps from three perspectives. First, the public's perception of anesthesia and its inherent risks are examined in the context of recent media treatment of the subject. The physician who is aware of his patient's perception of anesthesia may be better equipped to deal with patient concerns regarding the risks of anesthesia. Secondly, the article presents several brief synopses of recent medical malpractice cases which resulted in large jury verdicts or out-of-court settlements. The cases were selected from many reported in the *American Trial Lawyers Reporter* to illustrate the magnitude of potential damage awards in cases resulting in death or serious injury to the patient. The article concludes with some risk reduction suggestions and a brief analysis of anesthesia claims data gathered by the Risk Prevention Department of the Medical Inter-Insurance Exchange of New Jersey.

THE PATIENT'S PERCEPTION

In current years, the public has become more informed about the risks of anesthesia. Unfortunately, the lay public not always is able to distinguish between the unpreventable occurrence and that caused by failure to exercise due care.

A recent example of media treatment on the subject is "Deep Sleep," from ABC-TV newsmagazine, *20/20*, which aired April 22, 1982. Viewers were told, "This year (1982) 6,000 patients will die or suffer brain damage" as a result of "human error, carelessness, and a critical shortage of anesthesiologists." The following is a brief account of the show, taken from a transcript provided by ABC.

Dr. Eli Brown, chairman of the department of anesthesia at Sinai Hospital, Detroit, was shown demonstrating the induction of anesthesia in a routine gallbladder operation. Reporter Tom Jarriel observed,

*From the Department of Professional Liability Control, MSNJ, where Dr. George is Director and Editor of *PLB* and Ms. Quattrone is Assistant Editor of *PLB*. Correspondence may be addressed to A. Ronald Rouse, MSNJ, Two Princess Road, Lawrenceville, NJ 08648.

"There is little margin for error; with general anesthesia it takes less than five minutes before a mistake can result in irreversible brain damage. When the anesthesia is administered properly the outcome is predictable."

A physician-attorney, Dr. Walt Ward, was interviewed next and remarked, "They're ... putting people down near death, and then bringing them back. And that's the problem sometimes, bringing them back."

Jarriel then cited what *20/20* considered "three significant problems that make anesthesia unnecessarily dangerous. Problem number one is human error ... the primary cause of anesthesia accidents." This opinion was affirmed by Dr. Ward who said, from his own experience, that "probably 80 to 90 percent of these terrible accidents could have been avoided with proper attention."

Next, Dr. Susan Dorsch, an anesthesiologist, was shown demonstrating the way an oxygen analyzer works. "This will alarm you, this will alert you, by this very irritating noise, that something is wrong and corrective action needs to be taken immediately," she said.

Jarriel observed, "These safety devices are not mandatory. Although an oxygen analyzer costs less than $700, one out of four hospitals does not have this backup safety device." Jarriel then interviewed the wife of a patient who experienced severe injury when at the end of surgery the oxygen was turned off instead of nitrous oxide. He noted that the hospital did not have an oxygen analyzer.

Jarriel defined problem number two as "a manpower shortage." He noted, "Places like Mobile, Alabama, do not attract anesthesiologists." Mobile's solution, he said, is the use of highly trained nurses. Nurses are not doctors, he said, "and in times of crisis, that difference has had tragic results."

A New York nurse anesthetist, who asked *20/20* to conceal her identity, told viewers how patients sometimes are left alone under anesthesia. "There is a hospital in New York City, where there are two anesthesia people covering five operating rooms." Jarriel asked, "And how do they do that?" The nurse replied, "Well, they run quickly and pray a lot."

Jarriel noted that the shortage of anesthesiologists "is expected to last until 1990." (Notably, on January 13, 1984, results of a survey undertaken by the American Society of Anesthesiologists (ASA) with assistance from the American Hospital Association were reported in the *American Medical News*. The survey revealed that only 9 percent of all operations are performed in the 37 percent of the responding hospitals which do not have the services of an anesthesiologist. Most of those hospitals are located in rural areas with a mean number of 81 beds.)

The *20/20* program then focused on what was identified as "problem number three, an uninformed patient." Dr. Louis Blancato, then president of the American Society of Anesthesiologists, was interviewed and said: "The patient should know who his anesthesiologist is, what he can do, and be able to discuss things with him."

Jarriel then interviewed the parents of a boy who, at the age of 8, underwent surgery to correct a "bedwetting problem." The boy suffered a cardiac arrest as a result of an anesthesia incident. The child, now 12, requires round-the-clock nursing care to keep him from "curling into a tight ball with muscle contractions." Volunteers were shown massaging the boy who could barely respond to stimuli. The parents told the viewing audience that no one explained the risks of anesthesia to them, nor did they ever meet the anesthesiologist. The parents said, "When these doctors made that mistake with our son, it was like taking a gun and killing him because they just about did kill him. In fact, they did kill him and they brought him back to life, and they gave him back to us without any feeling or anything. If my son was hit by a car out in the street, it would be a tragic situation. But to put your son in the hands of people you trust and have something like this happen, it's not the same."

Jarriel cautioned the viewing audience to "try to avoid unnecessary surgery. Try to avoid general anesthesia—a far less dangerous local, where the patient stays awake, is usually an option. Personally meet your anesthesiologist well before the operation, and ask a lot of questions. Even that will reduce the risk."

LITIGATION

The issue of litigation arising out of anesthesia mishaps was not dealt with directly on *20/20*. A brief review of recent cases cited in the *American Trial Lawyers Association Law Reporter* reveals a plethora of large settlements and jury verdicts in favor of the plaintiff in anesthesia cases. Common to many of these cases were allegations of improper intubation, inadequate monitoring, failure to timely diagnose anoxia, and administration of excessive amounts of anesthesia. A brief review of a few of these cases follows.

The case of Lake *v* St. Luke's Hospital, St. Louis City Circuit Court, No 792-3656, cited at 25 ATLA L. Rep. 278, involved a 34-year-old auto mechanic who was admitted to the hospital for a tooth extraction to be done under general anesthesia. The plaintiff alleged that in preparation for the administration of anesthesia, the defendant anesthesiologist placed the endotracheal tube into the plaintiff's esophagus instead of his trachea. It further was alleged that the error was not discovered for ten minutes, during which time the plaintiff suffered anoxia, resulting in cardiac arrest. It was determined that the plaintiff sustained anoxic encephalopathy which resulted in permanent neurological deficit.

In their defense, the hospital and anesthesiologist contended that the plaintiff's injury resulted from sudden, unforeseeable cardiac arrest. The case was settled for $2 million prior to trial in favor of the plaintiff who is confined to a nursing home.

A Mobile, Alabama, jury recently awarded $5 million for the wrongful death of 39-year-old laborer whose malignant hyperthermia during surgery allegedly went undiagnosed. In that case, Hodge *v* Lane, Bryant, Eubanks, et al., Mobile County Circuit Court No. CV-79-001289, reported at 26 ATLA Rep. 328, the patient was admitted to the hospital for removal of a foreign body from his eye. General anesthesia allegedly was administered by a nurse-anesthetist who was employed by the defendant anesthesia group. According to the ATLA report, the patient exhibited tachycardia and temperature elevation during surgery but the

nurse-anesthetist, who did not employ an electronic temperature monitoring device, failed to note the patient's deteriorating condition. The nurse did not call the attending anesthesiologist, who was working at another hospital, until the patient suffered cardiac arrest. It also was alleged that the anesthesiologist who was on first call also was unavailable. The patient sustained severe brain damage and died nine months later.

Unfamiliarity with monitoring equipment was cited as a contributing factor in a signficant number of anesthesia mishaps.

A recent New York case, Chin *v* St. Vincent Hospital, N.Y. County Supreme Court, No. 11620/80, 25 ATLA Rep. 278, resulted in a settlement of $1,351,000 in favor of a 32-year-old stewardess who suffered respiratory arrest following an alleged administration of excessive amounts of anesthesia.

The patient, who weighed about 100 pounds, was admitted to the hospital after fracturing her arm in a skating accident. Prior to surgery, she received Atropine®, Demerol®, and Valium®, IM. While in the operating room she also received 25 mg Demerol® IV and a regional anesthetic. The patient suffered respiratory arrest and was not resuscitated for five to nine minutes, during which time she became comatose. The patient suffers from severe spasticity of the upper limbs and deficits in speech, sight, and movement.

A Maryland jury returned a verdict for $6 million in favor of a 38-year-old woman who suffered a cardiac arrest during surgery for removal of an ovarian cyst. Subsequently, the hospital and anesthesiologist were sued. The plaintiff alleged inadequate ventilation, improper volume reduction of an audible cardiac monitor and alarm, and failure to respond to the patient's need for postoperative hydration. The case is Margolis *v* Kim, et al., D.C. Superior Court, No. CA16740-80, 26 ATLA L. Rep. 132.

The case of Magnuson *v* U.S., U.S. District Court, D. Minn., No. 3-82-26, 26 ATLA Rep 134, resulted in settlement of $278,062 for the wrongful death of a 53-year-old cancer victim who became hypotensive under anesthesia. The patient, who had squamous cell carcinoma, was admitted to a VA hospital for a laryngectomy. During the induction of halothane anesthesia, the patient allegedly became hypotensive. Allegations in the lawsuit included delayed resuscitation, excessive amounts of halothane, negligent failure to mix halothane with oxygen, failure to provide a preoperative anesthesia consultation, and failure to have an anesthesiologist present during the induction of anesthesia.

RISK REDUCTION

As the cases reported above indicate, there perhaps is no other medical specialty which calls for the high degree of vigilance as does anesthesiology. Besides remaining vigilant, alert, and aware, what can the anesthesiologist do to minimize the risk of anesthesia mishaps?

An article, "Seven Sensible Steps to Safety and Salvation," by Drs. Jeffrey B. Cooper and Ronald S. Newbower and Charlene D. Long, M.S., published in the May/June 1980 issue of *Malpractice Digest* (St. Paul Fire and Marine Insurance Co.), offered the following suggestions:

1. Know the equipment. Unfamiliarity with monitoring equipment was cited as a contributing factor in a significant number of anesthesia mishaps. Acquiring a sound theoretical and working knowledge of all anesthesia apparatus and obtaining appropriate instruction on the use of new equipment is likely to reduce error.

2. Identify and eradicate pitfalls. Examine your own practice to determine whether any frequent albeit "minor" incidents can be identified. The authors noted that in two of the hospitals they studied, a pattern of "syringe swaps" evolved. The errors of selecting the wrong drug syringes were traced to the lack of a standard protocol for the sizes and labeling of drug syringes.

3. Select appropriate "vigilance aids." Oxygen monitors, ventilation disconnect alarms, and temperature monitors may reduce the incidence of midsurgical procedure mishaps, when the anesthetist's concentration or level of awareness may be somewhat reduced by fatigue.

4. Organize your workspace. Careful arrangement of drugs and syringes and an organized layout of apparatus are essential.

5. Examine your equipment. Even experienced anesthesiologists on occasion may fail to note whether all appropriate apparatus and drugs are available and to test for proper equipment function. The authors suggest mandatory use of a written equipment checklist in every case.

6. Maintain your equipment. Inadequate maintenance of equipment can contribute to human error. Report any damage or suspicion of damage to appropriately trained and experienced personnel for repair.

7. Identify "predisposing" factors. A few of these were identified by the authors as inadequate periods of rest or time off after night call, haste, the presence of visitors, last minute switching of equipment and schedules, and emotional stress and interpersonal conflicts.

The Department of Risk Prevention of the Medical Inter-Insurance Exchange of New Jersey recently completed a statistical analysis of anesthesia claims in which payment has been made to claimants through December 31, 1983. Although the data base is too small to recall any statistically significant pattern of mishaps and their causes, the data suggest the emergence of possible trends in anesthesia liability.

Out of the 171 paid anesthesia claims, 103 were solely "tooth cases." The relative frequency of these less significant claims suggests that increased care with regard to the patient's dentition will result in fewer claims and lawsuits.

The remaining 68 paid cases resulted in payments to claimants totalling $7.5 million, with an average

paid indemnity of $111,384.

The data also revealed that anesthesia claims involving the use of halothane and claims alleging failure to intubate (claims which were prevalent in the 1970s) appear to be abating. It is speculated that the reduction in the frequency of these claims is directly the result of the awareness by anesthesiologists of the magnitude of the problem and their successful risk-reduction actions in the wake of a pattern of such serious incidents.

Of the 68 substantial paid claims, two troublesome areas in anesthesia management emerged. These are: (1) the improper choice of anesthetic agent or other drug or medical error; and (2) the administration of anesthesia in patients who are poor candidates for surgery. Analysis of claims in the latter category suggest that when examined in the cold light of another day, the anesthesiologist's decision to clear the patient for surgery would not have been made.

Lack of communication or lack of effective communication between physicians may lie at the root of this difficult area of anesthesia practice. Many anesthesiologists practice in groups where it is routine for one anesthesiologist to make the preoperative rounds and for another anesthesiologist to conduct the anesthesia the next day. All too often there is poor communication between the evaluating physician and the physician who actually conducts the anesthesia. The evaluating physician may be well advised that simply charting his concerns about the patient may not be sufficient communication when the concern is of significance and the patient is scheduled for the operating room. Direct telephone communication may be the optimal method of ensuring that the concern is acted upon in a timely manner.

Communication between the anesthesiologist and the surgeon also is an area of serious concern to all involved. Often, patients are "tracked" and prepared for surgery by their surgeon. Given the pressures of hospital practice, the anesthesiologist occasionally may be reluctant to call a halt to planned surgery. However, the anesthesiologist must be mindful of the fact that every member of the health care team is legally responsible for his own actions. Prudence may dictate that surgery be postponed until additional studies and consultations are available for analysis. Effective communication with the surgeon in this area may result in fewer anesthesia incidents to the benefit of all involved.

CONCLUSION

It generally is agreed that anesthesiologists have done and can do a great deal to reduce the incidence of serious anesthesia mishaps. Awareness of the problem areas of anesthesia practice can create a climate for corrective action. If even a small percent of anesthesia claims can be avoided, the quality of medical care will be improved and a significant saving of insurance dollars can result.

Motrin®
ibuprofen, Upjohn
600 mg Tablets



More convenient for your patients.

Upjohn

'84 The Upjohn Company

The Upjohn Company • Kalamazoo, Michigan 49001 USA

J-4044 January 1984

When It Comes To HOME HEALTH CARE HoMed Provides The PASSPORT HOME...



HOMED has more than 25 Years of Professional Experience in Providing Home Health Care Products & Services To Families, Agencies and Institutions...

- CONVALESCENT EQUIPMENT & REPAIRS
- OXYGEN & RESPIRATORY THERAPY
- PARENTERAL/ENTERAL NUTRITIONAL THERAPY
- INFANTILE APNEA MONITORING
- BARRIER-FREE HOME MODIFICATION
- SPECIALIZED HEALTH PROFESSIONAL REGISTRY

HOMED™ ...the Home Health Care Company

Serving the Greater Metropolitan Area

CALL TOLL FREE 24 HOURS A DAY

NORTHERN NEW JERSEY (800) 452-9777 SOUTHERN NEW JERSEY (800) 392-6936

Deaths Related to Narcotics Overdose in New Jersey

Elizabeth Feuer, M.D., and John French, M.A., Trenton*

Abuse of "hits," an oral combination of codeine and glutethimide, has been on the increase. Some features of persons dying of "hits" overdose are discussed and compared with characteristics of those dying from overdose of heroin and methadone. The contribution of alcohol to heroin overdose is stressed.

In early 1982, we studied mortality in New Jersey due to a new drug combination, known as a "hit." A "hit" is an oral combination of 60 mg of codeine, usually in the form of aspirin, phenacetin, caffeine, and codeine, and 500 mg of glutethimide. Word-of-mouth reports indicate that this agent has become increasingly popular in northeastern New Jersey in the past several years. A report of the results of our study on the descriptive epidemiologic features has been published previously.[1]

For purposes of comparison, we collected data on deaths related to heroin and methadone. Examination of the characteristics of persons dying of overdose of these three agents forms the basis of this paper. In addition to the previously presented demographic characteristics, which we briefly recapitulate, we now offer data on autopsy and toxicologic findings which shed further light on the mortality experience related to these three drugs. We also discuss the issue of polydrug abuse involving narcotics.

METHODS

The Toxicology Laboratory of the Office of the State Medical Examiner serves as the sole resource for toxicologic testing for the county medical examiners of the state. Specimens from approximately 3,000 autopsies are submitted each year, including all deaths occurring under unknown or suspicious circumstances in which drug use is suspected to play a role. In such cases, specimens of tissues and body fluids are submitted and tested for a wide variety of drugs.

We reviewed the toxicology records for 1980 and 1981, and abstracted information on any deaths with a positive test for one of the three agents of interest. Demographic data, county of residence, and toxicologic data were obtained. Deaths then were classified as overdose deaths, drug-related deaths, and incidental deaths (indicating that drugs were unrelated to the cause of death). Only overdose deaths were examined in detail, by review of autopsy and toxicologic findings.

Because of the multiplicity of agents found in many autopsies, classification into categories at times was arbitrary. We used the following system: heroin—presence of morphine-quinine or morphinans-quinine; methadone—presence of methadone; "hits"—presence of codeine-glutethimide or morphinans-glutethimide. These categories, called primary agents, were structured so as to be mutually exclusive; individuals with positive findings in more than one category were classified as mixed. Deaths involving combinations of primary agents with other narcotics, such as meperidine and hydromorphone, were excluded. In addition, drugs such as alcohol,

*From the New Jersey State Department of Health. Correspondence may be addressed to Dr. Feuer, Division of Epidemiology and Disease Control, CN 360, New Jersey State Department of Health, Trenton, NJ 08625.

TABLE 1

Demographic Characteristics of Deaths due to Hits, Heroin, and Methadone, 1980-1981

	Hits		Heroin		Methadone	
	No.	%	No.	%	No.	%
Total	36	100.0	126	100.0	46	100.0
Male	31	86.1	104	82.5	37	80.4
White	16	44.4	56	44.4	30	65.2
Nonwhite	15	41.7	47	37.3	6	13.0
Unknown			1	0.8	1	2.2
Female	5	13.9	22	17.5	9	19.6
White	1	2.8	5	4.0	7	15.2
Nonwhite	4	11.1	17	13.5	2	4.3
Median Age						
Male	21		29		25	
Female	31		27		31	
Combined	22		28		26	

TABLE 2

Autopsy Findings in Deaths due to Hits, Heroin, and Methadone, 1980-1981

	Hits		Heroin		Methadone	
Findings*	No.	%	No.	%	No.	%
Pulmonary edema	36	100.0	107	94.7	37	94.9
Cerebral edema	19	52.8	63	55.8	19	48.7
Congestion of kidney	21	58.3	57	50.4	15	38.5
Congestion of spleen	20	55.6	49	43.4	12	30.8
Congestion of liver	17	47.2	48	42.5	10	25.6
Fatty liver	1	2.8	14	12.4	3	7.7
Cirrhosis	0	0.0	9	8.0	0	0.0
Gastrointestinal bleeding	2	5.6	3	2.7	2	5.1
Fresh needle marks	1	2.8	54	47.8	3	7.7
"Tracks"	7	19.4	48	42.5	9	23.1

*Percent refers to percent positive among those reviewed.

barbiturates, or marijuana may have been present. The presence of these agents did not affect classification of the case.

RESULTS

Numbers and characteristics of overdose deaths related to the three primary agents are shown in Table 1. There were 36 deaths related to "hits" overdose, 126 related to heroin overdose, and 46 related to methadone overdose; in addition, there were ten heroin-methadone mixtures, seven heroin-"hits" mixtures, and two methadone-"hits" mixtures. Males predominated in all three groups; however, the racial composition of the groups differed somewhat. The methadone cases showed a marked predominance of whites (80.4 percent), whereas only 48.4 percent of heroin deaths and 47.2 percent of "hits" deaths were white. The median ages of the three groups showed some variation. The heroin group was the oldest, at 28 years; "hits" deaths had a median age of only 22 years.

The results of the review of the autopsy data are presented in Table 2. We reviewed the autopsy reports for 36 "hits" deaths, 113 heroin deaths, and 39 methadone deaths, for an overall completion rate greater than 90 percent. The most common findings related to visceral congestion: pulmonary edema, cerebral edema, and congestion of kidney, liver, and spleen. Methadone deaths showed these findings less frequently than did heroin or "hits" deaths.

Mention of the presence of fresh needle marks and of track marks specifically was sought. Both findings occurred significantly more frequently among heroin users. Differences in proportions showing fresh needle marks were particularly striking; fresh marks were found in 47.8 percent of heroin deaths, but in only 7.7 percent of methadone deaths ($\chi^2 = 18.2$, $P < .001$) and 2.8 percent of "hits" deaths ($x^2 = 21.8$, $P<.001$), implying that persons dying of methadone and "hits" overdose are not current parenteral narcotics users. Differences in proportions with venous scars or track

TABLE 3

Toxicologic Findings in Deaths due to Hits, Heroin, and Methadone, 1980-1981

	Hits		Heroin		Methadone	
Toxicologic Findings	**No.**	**%**	**No.**	**%**	**No.**	**%**
Primary agent alone	25	69.4	17	13.5	12	26.1
Primary agent with alcohol	2	5.6	88	69.8	16	34.8
with alcohol only	1	2.8	75	59.5	6	13.0
with alcohol and depressant	1	2.8	7	5.6	5	10.9
with alcohol and other	0	0.0	6	4.8	5	10.9
Primary agent with depressant	7	19.4	12	9.5	8	17.4
Primary agent with other	2	5.6	9	7.1	10	21.7
Total	36	100.0	126	99.9	46	100.0

marks also were significant for "hits" ($\chi^2 = 5.27$, $P < .025$) and for methadone ($\chi^2 = 3.86$, $P < .05$) compared to heroin deaths.

An interesting group of findings related to the stigmata of alcoholism, particularly fatty liver and cirrhosis. Fatty liver was found in 12.4 percent of heroin deaths, as opposed to 7.7 percent of methadone deaths, and only 2.8 percent of "hits" deaths. Cirrhosis was found only in the heroin group, in 8.0 percent of autopsies. Although these results are not significant statistically, they are consistent with one another and show an intriguing pattern.

Toxicologic findings are summarized in Table 3. Striking differences are found between the groups in the occurrence of drugs other than the primary agents. "Hits" deaths tend to reveal a pattern of little associated drug use, with 69.4 percent of deaths showing "hits" as the only agent. This situation is reversed for the heroin group. Only 13.5 percent of heroin deaths showed no other drug present. Of the additional drugs found, alcohol was the most important. Combinations involving alcohol were found in 69.8 percent of heroin deaths. Methadone deaths showed intermediate values, with 34.8 percent of deaths indicating the presence of alcohol; only 5.6 percent of "hits" deaths showed alcohol present. These results are significant ($P < .001$).

DISCUSSION

The major limitation of this study is its exclusive focus on mortality data. The implication is strong that polydrug abuse, especially involving alcohol, increases a user's risk of death. However, without data on general use patterns, it is impossible to state this with certainty. These results merely may reflect use patterns; polydrug use may simply be the norm, and the deaths we have reviewed, rather than indicating a group at special risk of dying, may be representative of the broader population of drug users.

We undertook this investigation to examine the effect of "hits" on drug overdose mortality in New Jersey. As our analyses advanced, however, we found that more general patterns of overdose mortality emerged from the data. Age, race, and sex distributions differ somewhat among groups. "Hits" deaths tend to be younger than either methadone or heroin deaths; methadone deaths show a more marked predominance of whites. Males outnumber females in all three groups. Whether this reflects heavier usage among specific population subgroups, or greater susceptibility to overdose death among certain groups, is impossible to state from these data alone. However, results of the autopsy review and of the toxicologic review give further clues.

Users have reported to us that "hits" are an attractive substitute for heroin, because they are obtained easily and they are taken orally. Users can avoid the physical signs of heroin use. This same argument may apply to oral methadone use as well. It seems probable that these oral narcotics mainly attract the younger, less experienced, and perhaps nonhabituated user, who is at greater risk of death through overdose. This hypothesis is borne out by the lower prevalence of track marks among both "hits" and methadone users; the lower prevalence of fresh needle marks is even more pronounced, implying that the oral narcotics users are not concomitant users of heroin.

Both "hits" and methadone contain prescription pharmaceuticals of a high degree of purity. In contrast, street heroin has been of low potency in recent years. It is possible that the potency of "hits" and of methadone is greater than that of currently available heroin, and that the least experienced users may in fact be gravitating toward the more potent agents. One point that is quite clear from the data is that "hits" by themselves are potent enough to lead to fatal overdose; nearly 70 percent of "hits" deaths had no other agent present. Therefore, it cannot be assumed that because a narcotic is taken orally it is necessarily safe. In contrast, only 13.5 percent of heroin deaths involved no other agent; nearly 87 percent were in combination, usually with alcohol. This merely may reflect patterns of use, i.e. that heroin users almost invariably drink alcohol. However, it may be equally well interpreted as showing that combined use of heroin and alcohol increases a user's risk of death.

The autopsy review seems to indicate that alcoholism is a significant occurrence among heroin users. The median age of the series was only 28 years, however, 8.0 percent of those autopsied had cirrhosis. Fatty liver, indicating more acute alcohol toxicity, was found in 12.4 percent. Focusing on the problem of alcohol abuse in persons under treatment for their heroin problem may be a worthwhile activity.

One possibility concerning the mortality due to "hits" is that a synergism between the narcotic and the sedative components was responsible for a more profound central nervous system depression, leading to death. Review of the toxicologic data on heroin and methadone lends support to the idea that narcotics combined with depressants are notably dangerous. For methadone-related deaths, 52.1 percent involved a combination including a central nervous system depressant; for heroin, 79.3 percent. Including all three drugs, and viewing hits as such a narcotic-depressant combination, 76.9 percent of the narcotics deaths we reviewed were of this combined type. It appears that polydrug abuse involving narcotics and alcohol is a major problem. Correlation of mortality data such as this with clinical data from physicians involved in the treatment of drug abusers may be helpful in clarifying how large a role polydrug use of this type plays in the current drug scene. Restructuring of treatment programs better to serve these multiple-drug users may be worthwhile.

SUMMARY

We report the occurrence of 36 deaths attributable to "hits" overdose in New Jersey during 1980 to 1981. During the same period, 126 fatal heroin overdoses and 46 fatal methadone overdoses were found. Users dying of "hits" overdose were younger than those dying of overdose of heroin; autopsies of "hits" and methadone users revealed few signs of intravenous narcotism. Victims of heroin overdoses showed at postmortem an impressive incidence of findings related to heavy alcohol use. Toxicologic analyses bore out this association. The dangers of oral narcotic abuse, and of narcotic-depressant combinations, are highlighted by these findings.

REFERENCE

1. Feuer E, French J: Descriptive epidemiology of mortality in New Jersey due to combination of codeine and glutethimide. *Am J Epidemiol* (in press).

ACKNOWLEDGEMENTS

The authors gratefully acknowledge the assistance of Dr. Robert Goode, the New Jersey State Medical Examiner, and Dr. Robert Javier, Assistant Director of Toxicology, of the State Medical Examiner's Office. We express our appreciation to Dr. Ronald Altman, Assistant Commissioner of Epidemiology and Disease Control, and to Dr. William Parkin, State Epidemiologist.

BROWN **THE BROWN PHARMACEUTICAL CO., INC.**

2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

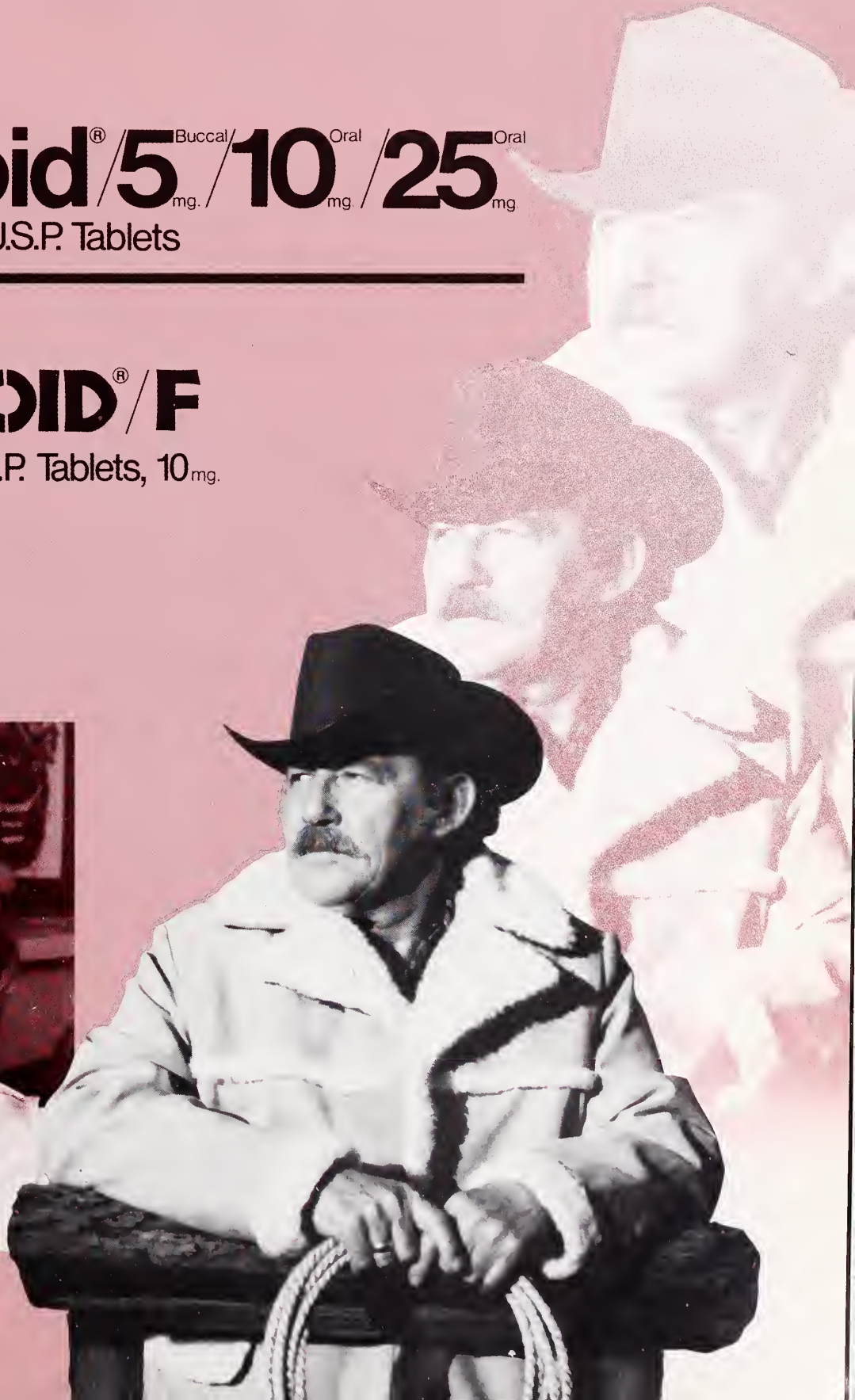
Android®/5 mg. Buccal/10 mg. Oral/25 mg. Oral

Methyltestosterone U.S.P. Tablets

ANDROID®/F

Fluoxymesterone U.S.P. Tablets, 10 mg.







Only Burroughs Wellcome Co. gives you

ZYLOPRIM®
(allopurinol)

and a whole lot more!

Full support for you, the physician:

- Continuing medical education materials
- On-going clinical studies
- Physician consultation readily available for your questions concerning Zyloprim
- A choice of 100 mg and 300 mg scored tablets

Full support for your patients:

- Patient starter/conversion kits for easy titration of initial dosage
- Patient education pamphlets to encourage compliance
- Burroughs Wellcome Co. quality and economy

Wellcome / **Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709

Computerized Tomography-Guided Percutaneous Needle Biopsy

Kenneth L. Jewel, M.D., Montclair*

A reappraisal of a recently published series confirms the usefulness and safety of percutaneous needle biopsy with computerized tomographic guidance. With recent modifications, the acceptable accuracy rate of 84 percent has been increased significantly to 95 percent.

Percutaneous needle biopsy (PNB) utilizing direct imaging techniques has been used by many workers safely and effectively to remove tissue samples from various organs and anatomic locations in the body.[1-4] Jewel and Kimler reported their experience in 120 consecutive cases with a diagnostic accuracy of 84 percent.[5] It has been presumed, with increasing experience, that many diagnostic and therapeutic procedures would become safer and more precise. Since February 1982, 130 additional cases have undergone PNB. It is the purpose of this report to analyze the improved success rate and decreased complication rate, and to compare this series with previously published material.

METHODS AND MATERIALS

Between February 1982 and June 1983, 130 consecutive cases underwent PNB. Nearly all procedures were performed utilizing computerized tomographic (CT) guidance (Figure). Occasionally, if a mass was large enough, the biopsy was performed with fluoroscopic assistance after appropriate markers were placed on the skin. The precise depth was calculated utilizing CT. Biopsy needle types[6] and localization techniques[7,8] have been described previously. All cases initially were biopsied with a 22-gauge Franseen needle.** If pathologic material was inadequate, and clinical and/or technical considerations dictated, an 18-gauge Tru-Cut needle*** was utilized. The pathological material was removed and was handled as has been described previously.[5]

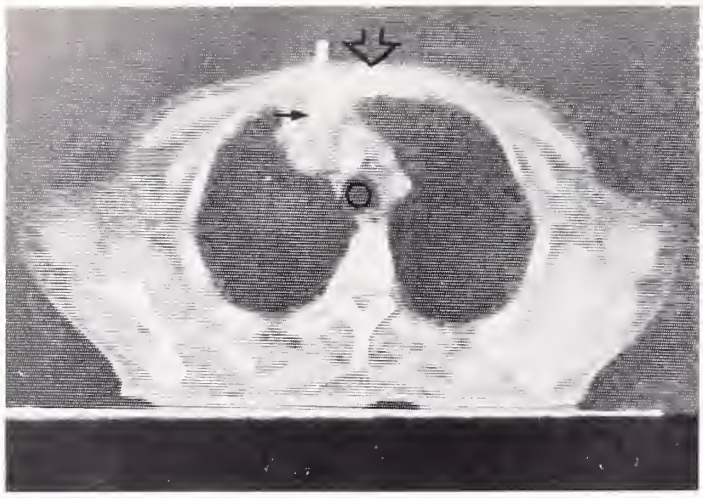
RESULTS

All 130 consecutive cases were analyzed. Approximately 50 percent of the case material consisted of lung and/or mediastinal biopsies (64 cases) with the liver and pancreas frequently being biopsied as well (Table). True positive (TP) results were obtained when a diagnosis of malignancy was established or when a specific benign diagnosis was made cytologically or histologically. False negative (FN) diagnoses were recorded when a proved malignant diagnosis was obtained by a subsequent method (thoracotomy, mediastinoscopy, or exploratory laparotomy) and the initial PNB had been recorded as negative for malignancy. False positive (FP) diagnoses did not occur in this series indicating a specificity of 100 percent. True negative (TN) cases were reported when a benign disease process was identified by PNB and subsequently proved by clinical followup and/or other diagnostic means. The overall accuracy rate in this series was 95

*Dr. Jewel is Director, Department of Radiology, The Mountainside Hospital, Montclair. Correspondence may be addressed to Dr. Jewel, The Mountainside Hospital, Bay and Highland Avenues, Montclair, NJ 07042.

**Cook Incorporated, Bloomington, IN 47402.

***Travenol Laboratories, Incorporated, Deerfield, IL 60015.



Figure—CT through the upper chest discloses a somewhat irregularly marginated mass situated slightly to the right of the sternum (large arrow). The trachea (O) is identified and the appropriate positioning of a 22-gauge biopsy needle within the mass clearly is identified (small arrow).

percent.

Complications of the procedure were extremely uncommon and were limited to those patients with lung and/or mediastinal biopsies. Three cases of minimal pneumothorax (constituting less than 10 percent of lung volume) and one case of clinically insignificant hemothorax were encountered. None of these patients required chest tube insertion or transfusion and clinically these complications were considered minor.

DISCUSSION

Since 1979, 250 cases have been referred to the department of radiology for percutaneous needle biopsy. Our initial success rate of 84 percent previously has been described.[5] An ongoing analysis of technique and methodology has been underway with continual refinements and adjustments.

The underlying basis for the high rate of success in this and other series is the use of direct image-guided technique whether by ultrasound, fluoroscopy, or CT. While the use of a so-called "fine or skinny" needle is preferred, there are many instances where insufficien pathologic material is removed with a 22-gauge needle A more satisfactory core of tissue can be recovere using a larger cutting needle. By estimating th vascularity of a mass to be biopsied as has bee previously described by Haaga,[9] inadvertent biopsy o a vascular mass with a larger needle can be avoided A larger sample of tissue helps the pathologist t render a correct tissue specific diagnosis more often In addition, those tissue types which notoriously ar difficult to diagnose (such as lymphoma an plasmocytoma) can be delineated correctly.

A somewhat subjective but important reason for th increased accuracy rate in this series concerns th greater experience of the interventional radiologis performing the procedure. In the majority of cases, a distinct feel or sensation of "grittiness" is encountere upon entering the abnormal tissue. This is a con firmatory sign of proper needle placement and has been most helpful. Certainly, with added experience pathological expertise has increased as well.

Because of the high accuracy rate, an initial negative diagnosis with strong clinical suspicion of malignancy may warrant repeat PNB. This particularly is useful in elderly and/or debilitated patients where more invasive procedures may be planned.

With increasing numbers of cases seen as outpatients, the technique becomes even more cost effective. Our complication rate is extremely low with only four cases encountering any untoward effect (3 percent). These were minor and required no treatment.

SUMMARY

With minor but important modifications, PNB utilizing direct image-guided technique has become a major means of establishing thc correct diagnosis at this institution. The initial accuracy rate of 84 percent described in an earlier report has been increased dramatically to 95 percent with an even lower complication rate. This series further confirms the experience reported in large university centers and illustrates the usefulness of PNB as a cost-effective, safe, and highly

TABLE

Biopsies

Anatomic Site	Number Biopsied	TP	TN	FP	FN	Sensitivity Percent	Specificity Percent	Overall Accuracy Percent
Chest	64	48	12	0	4	92	100	94
Liver	20	13	5	0	2	87	100	90
Pancreas	16	11	5	0	0	100	100	100
Abdominal or retroperitoneal mass (including lymph node, kidney, adrenal	19	13	5	0	1	93	100	95
Bone	11	8	3	0	0	100	100	100
Total	130	93	30	0	7	93	100	95

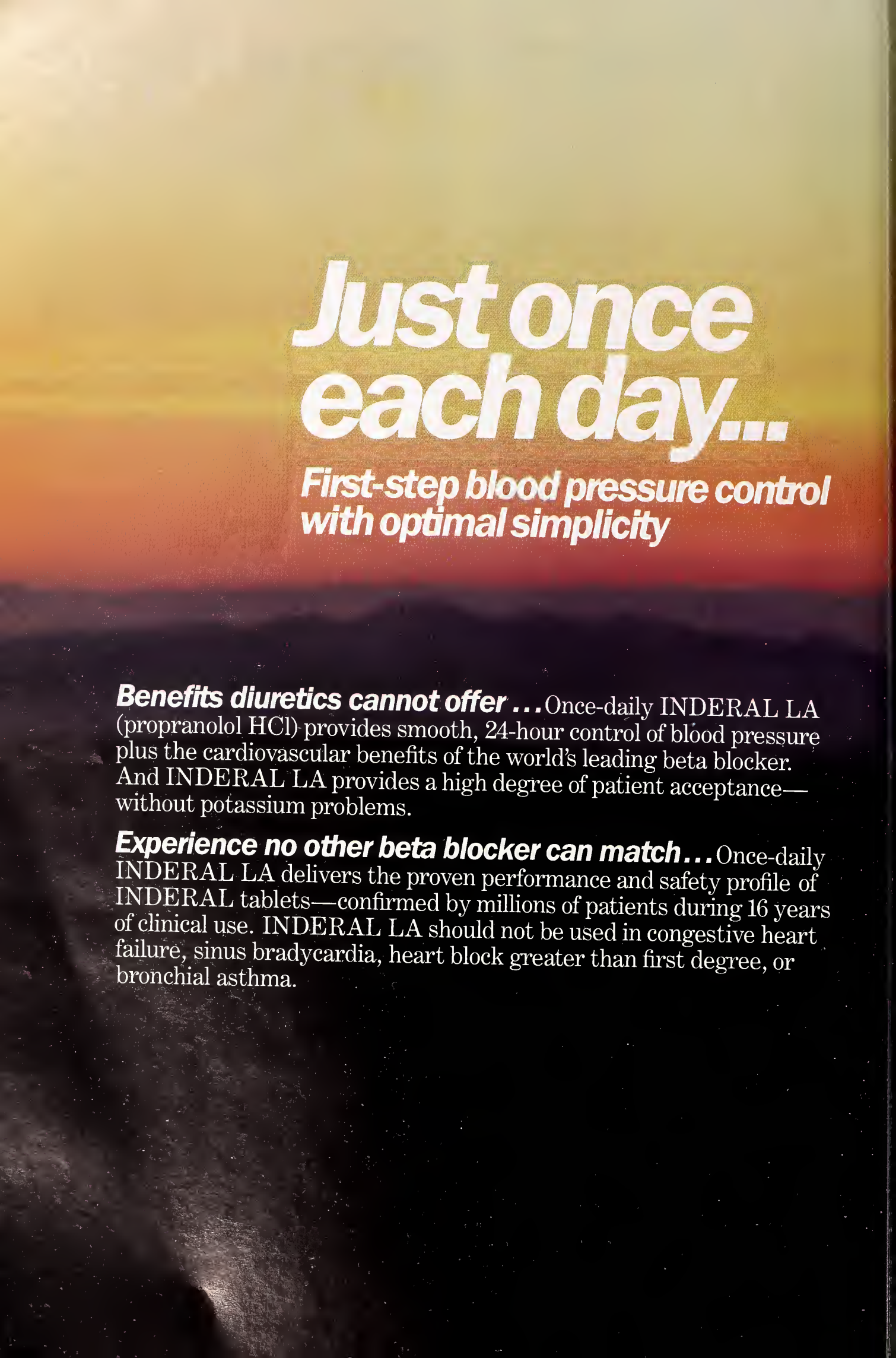
TP=true positve; TN=true negative; FP=false positive; FN=false negative

$$\text{Sensitivity} = \frac{(TP)}{(TP+FN)} \times 100 \qquad \text{Specificity} = \frac{(TN)}{(TN+FP)} \times 100 \qquad \text{Overall accuracy} = \frac{(TP+TN)}{\text{Total No. of Biopsies}} \times 100$$

accurate procedure in community hospitals where interventional radiologic expertise exists.

REFERENCES

1. Olga AB, Rosenberger A, Peleg H: Fine-needle aspiration biopsy of mediastinal masses: Evaluation of 136 experiences. *Am J Roentgenol* 140:893-896, 1983.
2. Gross BH, Goldberg HI, Moss AA, Harter LP: CT demonstration and guided aspiration of unusual adrenal metastases. *J Comput Assist Tomogr* 7:98-101, 1983.
3. Gotenby RA, Mulhern CB, Strowitz J: CT-guided percutaneous biopsies of head and neck masses. *Radiology* 146:717-719, 1983.
4. Harter LP, Moss AA, Goldberg HI, Gross BH: CT-guided fine-needle aspirations for diagnosis of benign and malignant disease. *Am J Roentgenol* 140:363-367, 1983.
5. Jewel KL, Kimler S: Percutaneous fine-needle biopsy using direct imaging techniques. *J Med Soc NJ* 79:731-733, 1982.
6. Haaga JR, LiPuma JP, Bryan PJ, Balsara VJ, Cohen AM: Clinical comparison of small and large calibre cutting needle for biopsy. *Radiology* 146:665-667, 1983.
7. Ferrucci JR, Wittenberg J: Computed tomography biopsy of abdominal tumors: Aids for lesion localization. *Radiology* 129:739-744, 1978.
8. Haaga JR: New technique for computed tomography guided biopsies. *Am J Roentgenol* 133:633-641, 1979.
9. Haaga JR, Vanek J: Computed tomography-guided liver biopsy using the Menghini needle. *Radiology* 133:405-408, 1979.


Just once each day...
First-step blood pressure control with optimal simplicity
Benefits diuretics cannot offer . . . Once-daily INDERAL LA (propranolol HCl) provides smooth, 24-hour control of blood pressure plus the cardiovascular benefits of the world's leading beta blocker. And INDERAL LA provides a high degree of patient acceptance—without potassium problems.
Experience no other beta blocker can match . . . Once-daily INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.



Start with 80 mg once daily... Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



80 mg 120 mg 160 mg

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

Ayerst®

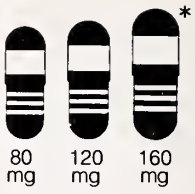
Just once each day for initial therapy in hypertension.

Just once each day for initial therapy in HYPERTENSION.

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the platelets of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly hydrolyzable.

INDICATIONS AND USAGE. **Hypertension:** INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease; elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses [illegible] times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks. (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

8950/284

Ayerst® AYERST LABORATORIES
New York, N.Y. 10017

Premenstrual Syndrome: Fact or Fantasy?

Marco A. Pelosi, M.D., Bayonne*

Media attention on premenstrual syndrome (PMS) has stimulated patients to demand attention from unsympathetic physicians. Patients are relieved to know that PMS is a real entity with a possible physiologic basis. The ultimate medical and legal acceptance of PMS could have some adverse effects for women.

Premenstrual syndrome (PMS) or premenstrual tension (PMT) has been "rediscovered" by the press. Several legal cases, publicized in England, have drawn considerable attention to PMS.[1] An inordinate number of patients suffering from the condition, whose symptoms often were ascribed to emotional factors, are demanding needed attention from allegedly unsympathetic physicians. We have experienced an unusual increase in the number of patients referred with PMS by primary physicians and psychiatrists. Patients often are relieved to learn that a physiological basis for the condition exists.

The current interest in PMS has led to the creation of premenstrual syndrome clinics in this country because: of the emergence of women's organizations devoted to the understanding and treatment of PMS, of the case reports of PMS as a gynecological problem, and of the recent use of PMS as a legal defense.[2]

DEFINITION

The symptoms of premenstrual syndrome start during the luteal phase of the menstrual cycle, i.e. from 14 days to 1 day before menstruation. There must be a symptom-free period of at least one week after menstruation stops. The diagnosis of PMS should be reserved until other pathophysiological and psychological conditions have been ruled out. The most frequent symptoms occur cyclically before menstruation onset and disappear during menstruation (Table 1).

PMS may occur at any time from menarche to menopause and will affect 30 percent of females in a relatively severe form at some time in their lives. Symptomatology may vary from patient to patient and may differ in intensity from one menstrual cycle to the next. Occasionally, PMS becomes more severe with age as some muscle tissue is replaced by fat providing a more efficient aromatization of estrogen. This phenomenon may raise the estrogen/progesterone ratio and lead to more severe symptoms.[2]

The definition of PMS is confused by the broad range, variable severity, and wide prevalence of symptoms, which raises questions of what is normal and what is baseline. The fact that many otherwise healthy women experience premenstrual discomfort, suggests that the cause is physiologic, but the rare occurrence of incapacitating symptoms suggests that the condition sometimes is pathologic.[3] The recent lesson learned about "primary or idiopathic" dysmenorrhea should not be forgotten. Not too long ago, lack of knowledge led us to conclude that dysmenorrhea implied either pelvic pathology or emotional instability. Now, it is well established that primary dysmenorrhea is a physiologic, although uncomfortable, response of the

*Dr. Pelosi is Clinical Associate Professor, Obstetrics and Gynecology, UMDNJ-New Jersey Medical School. Correspondence may be addressed to Dr. Pelosi, Pelosi Women's Medical Center, 738 Kennedy Boulevard, Bayonne, NJ 07002.

TABLE 1

Symptoms of Premenstrual Syndrome

Abdominal bloating	Irritability
Acne	Leg heaviness
Aggression	Lethargy
Anxiety	Loss of concentration or impaired coping ability
Breast engorgement and tenderness	Mood swings
Change in bowel habits	Muscle and/or joint pain
Change in libido	Nausea
Crying spells	Peripheral edema
Depression	Poor coordination/clumsiness/tendency to accidents
Edema	Pelvic pain
Fatigue	Pruritus
Food cravings	Rhinitis
Headache	Skin disorders
Hot flushes	Tension
Heaviness	Thirst
Increased appetite	Weight gain
Insomnia	

normal uterus to normal prostaglandins and not a psychogenic reaction. The notion that women with PMS are emotionally unstable suggests an admission of ignorance of the underlying physiology, which has led many physicians to doubt the existence of PMS.

INCIDENCE

The exact incidence of PMS is difficult to evaluate. Lauersen and Graves reviewed the subject and found the prevalence of PMS in otherwise healthy women ranged from 31.9 percent to 40 percent.[2] When PMS was defined as any combination of emotional or physical complaints that occurred before menstruation and disappeared toward the end of menstruation, only 3 percent of normal women escape the diagnosis of PMS. Consequently, it is essential to distinguish between patients with premenstrual changes considered tolerable or normal and those with severe symptoms. Premenstrual syndrome has a definite impact on work efficiency and absenteeism: among 1,500 women in one plant, 36 percent sought sedation in the premenstrual week.

ETIOLOGY

The exact etiology of PMS still is not known. Unfortunately, the undetermined cause of PMS is the single most important issue preventing the development of appropriate treatment. Etiological hypotheses have been numerous and varied (Table 2).

DIAGNOSIS AND CLASSIFICATION OF SYMPTOMS

The great variety of symptoms has confused the clinical picture of PMS. Recently, the problem has been simplified by Abraham, who divided the symptoms into four groups according to the major symptoms:[20]

1. **PMT-A:** Anxiety, irritability, and mood swings.
2. **PMT-D:** Depression, insomnia, and confusion.
3. **PMT-H:** Edema, weight gain, abdominal bloating, headache, breast engorgement and tenderness, and peripheral edema.
4. **PMT-C:** Increased appetite and craving for sweets and other foods.

The physician must be willing to accept the patient's symptoms as real and to investigate possible causes. Physical factors must be ruled out before attributing PMS to an emotional problem. A detailed medical, menstrual, sexual, and psychological history is imperative. A menstrual calendar should be reviewed. A general physical examination and a careful pelvic examination is mandatory with attention to ovarian masses, myomas, pelvic inflammatory disease, and endometriosis. Breast examination is important. When needed, ultrasonography, x-rays, mammography, CAT scan, and laparoscopy should be performed. When the Papanicolaou (pap) smear is taken, vaginal cytology to evaluate the hormonal status (maturation index) should be done. Primary or secondary dysmenorrhea often is associated with PMS. Cyclical depression with premenstrual onset, followed by prolonged depression, must be differentiated from PMS. Laboratory evaluation should include hemogram, blood chemistry, folliculo-stimulating hormone/luteinizing hormone (FSH/LH), serum estradiol, serum progesterone, serum prolactin, and thyroid profile. These tests should be performed during the premenstrual period, (one to seven days prior to menstruation) and/or at the time the symptoms are more severe. The foreknowledge of the patient's premenstrual hormonal status offers invaluable information, which usually is needed for treatment of the different types of PMS.[2]

The correlation between the categories of PMS with their pathophysiologic changes and suggested treatments are presented in Table 3.

TREATMENT

Since the cause of PMS is unknown, a number of empirical and even controversial treatments have been used (Table 3). Therapy must be individualized and include emotional support and acknowledgment of the reality of the patient's physical and psychological symptoms. On the other hand, both the patient and the physician should avoid blaming PMS for unrelated dysfunctions.

A general approach which has proved to be successful should be tried in all PMS patients.[2] The following program might avoid the need for medical therapy in approximately 40 percent of patients:

1. Reduction of calorie intake because increased body weight and the conversion of fatty tissue to estrogen may exacerbate the symptoms. During the premenstrual period, reduction in salt intake is advised to prevent water retention. A low-sugar, high-protein diet divided into five or six small feedings seems to benefit many patients. Some patients may need to remain on a hypoglycemic diet to reduce blood sugar fluctuations.

2. Vitamin B_6 (pyridoxine), 50 to 800 mg/day, has produced marked improvement in combination with a high-protein, low-salt, and low-sugar diet. The vitamin regulatory role in brain monoamine production (acting as a coenzyme in the biosynthesis of dopamine and serotonin) is thought to be effective in treating such symptoms of PMS, as depression, tension, anxiety, aggression, or irritability.

3. Increase physical activity and exercise in order to promote metabolism and rebuild muscle mass. Athletes tend to experience less premenstrual tension and fewer headaches than nonathletes, but not less

TABLE 2

*Etiology of Premenstrual Syndrome**

Author	Year	Theory
Frank[4]	1931	Decreased renal clearance.
Sweeney[5]	1934	Disturbance of the sympathetic nervous system.
Israel[6]	1938	Defective luteinization resulting from progestin deficiency or relative hyperestrogenemia.
Thorn, et al.[7]	1938	Decreased urinary output, with retention of sodium and chloride.
Greenhill and Freed[8]	1940	Estrogen-induced salt and water retention.
Biskind[9]	1943	Estrogen excess due to decreased liver clearance. Vitamin B recommended.
Billig and Spaulding[10]	1947	Hyperinsulinism.
Stieglitz and Kimble[11]	1949	Endometrial toxin which could be treated with ammonium nitrate.
Morton[12]	1950	Increased carbohydrate tolerance and abnormal glucose tolerance curve. Recommended vitamin B complex, high-protein, low-salt, low-sugar diet.
Bickers and Woods[13]	1951	Vasopressin-induced water intoxication.
Greene and Dalton[14]	1953	Introduced for the first time the concept of a syndrome. Progestin therapy.
Rees[15]	1953	Found psychotherapy of limited value and recommended individual therapy.
Mukherjee[16]	1954	Found flat glucose tolerance curves during the luteal phase.
Jones and Gordon[17]	1969	They found no allergic component to sex hormones in PMS.
Farah and Shbaklu[18]	1971	They found no allergic component to sex hormones in PMS.
Reid and Yen[19]	1981	Multifaceted psychoneuroendocrine disorder involving a dysfunction in the hypothalamus, pituitary, and ovarian axis. PMS is due to an atypical release of/or a sensitivity to the neurointermediate lobe peptide alpha melanocyte-stimulating hormone and beta-endorphins during the luteal phase.

*Based on Shangold's Review[3]

edema. Significant heaviness, lethargy, and impairment of performance before menses may persist despite exercise.[44]

4. Avoid situations and people who are upsetting; get plenty of sleep.

5. Attempt to deal with stress more effectively. Psychotherapy alone has proved to be of limited value.

HORMONES AND OTHER DRUGS

Patients with PMS who do not respond to the above program are candidates for medical treatment. If blood tests indicate a hormonal imbalance (usually a decrease in progesterone and estradiol ratio), natural progesterone vaginal suppository therapy might be successful. Normally, approximately 200 mg/day of progesterone is produced during the luteal phase but because of the loss of absorption through the vaginal mucosa, 200 mg to 400 mg b.i.d. is recommended.[2] Progesterone therapy in combination with counseling and the general program may eliminate PMS symptoms in approximately 80 percent of the patients.[2] Where a significant hormonal imbalance is not present and the symptoms are severe and/or persistent and other treatments failed, progesterone therapy may be tried. There are no oral natural progesterone tablets, since the hormone would be destroyed in the gastrointestinal tract. It is advisable to instruct the patients to insert the suppositories high in the posterior vaginal fornix and to stay in the supine position for several minutes after insertion to avoid leakage of the medication. Observations that PMS symptoms are maximal as progesterone levels fall may indicate that progesterone withdrawal, rather than progesterone deficiency, causes PMS. After tubal sterilization, some patients notice an increase of PMS symptoms. A decrease in the blood supply of the ovary, producing an abnormal luteal function with deficiency in progesterone output, may be the etiologic factor.[2]

Natural progesterone vaginal suppositories are not readily available; however, they can be prepared by a local pharmacy or ordered from a pharmaceutical manufacturer. Suppositories also are available from PMS clinics. Parenteral progesterone is not desirable because of its long-acting effects and interference with menstruation. No major side effects have been found to be associated with the cyclic use of progesterone suppositories, but the following may occur: tiredness, euphoria, breast engorgement, initial flush and feeling of warmth after insertion of suppositories, and nausea. In these cases, reduced dosage is advised.

Synthetic hormones, such as medroxyprogesterone (Provera®) and dydrogesterone, have not been found to be as effective, and occasionally may exacerbate the symptoms.[2] Uncontrolled studies have reported improved PMS symptoms with norethisterone, dimethisterone, and ethisterone.[45]

TABLE 3

Types of Premenstrual Treatments

Syndrome	Pathophysiology	Suggested Treatments
PMT-A: Anxiety, irritability, and mood swings.	• Elevated estrogen/progesterone ratio in the luteal phase.[21] • Plasma MAO activity relates directly to the plasma progesterone/estradiol ratio and is inversely proportional to plasma estradiol level.[22] • Estrogen decreases MAO activity, while progesterone increases it.[23] • Reduced RBC magnesium concentration is present in PMT-A.[24] • Magnesium and pyridoxine are needed for synthesis of brain dopamine; symptoms of PMT may result from their deficiency.[25,26]	• General program: diet modification (decreased calories, high-protein, low-salt, low-sugar diet, during the premenstrual period); exercise; counseling. • Vitamin B_6 (50 to 800 mg/day) (to decrease serum estradiol and increase progesterone.)[25,26,43] • Natural progesterone suppositories, 200 to 400 mg/day, b.i.d. 10 to 14 days prior to menstruation, discontinue at time of expected period.[2,41] • Oral contraceptives.[2] • Tranquilizers.[3]
PMT-D: Depression, insomnia, and confusion.	• Low brain concentration of norepinephrine.[27] • Lower serum estradiol levels and higher serum progesterone levels occur during the luteal phase.[28] • Progesterone therapy increases MAO activity and lowers catecholamine concentration. Progestins enhance metabolism of catecholamines. • Estrogen therapy decreases MAO activity and estrogen plus progesterone raises the MAO activity above the estrogen therapy level.[29]	• General program. • Vitamin B_6, vitamin B complex. • Antidepressive medication, sleeping drugs, psychotherapy, and counseling. • Progesterone suppositories or oral contraceptives, most likely will not be effective.
PMT-H: Edema, weight gain, abdominal bloating, headache, peripheral edema, breast engorgement, and tenderness.	• Increased aldosterone (premenstrually). • Higher levels of 11-desoxycorticosterone during the luteal phase. Both steroids produce fluid retention.[30-32] • Dopamine inhibits aldosterone synthesis.[33,34] • PMS patients have higher prolactin levels. Bromocriptine, a dopamine agonist, improves PMS symptoms.[35-38]	• General program. • Low-salt diet.[2,3] • Diuretics: spironolactone (antagonizes aldosterone action and inhibits steroid genesis) 25 mg. b.i.d. during the days of expected symptoms or 50 mg/day on symptomatic premenstrual days only and increasing to 50 mg/day throughout the cycle.[2,42] • Bromocryptine tablets (Parlodel®) 2.5 mg b.i.d. 10 to 14 days prior to menstruation in patients with increased prolactin levels.[35-38] • Combination of vitamin B_6 and vitamin A (to oppose thyroid hyperfunction or to create a direct antiestrogenic and diuretic effect). Progesterone therapy may be necessary if no improvement is noticed.[2]
PMT-C: Increased appetite and craving for sweets and other foods.	• Reduction of insulin receptors on monocytes during the luteal phase, produces a decreased insulin sensitivity and decreased carbohydrate tolerance.[39] PMS-C patients have flat glucose tolerance before menses.[12,40] The impaired glucose tolerance during the luteal phase which results in a rebound increased glucose tolerance during the premenstrual phase is believed to be the cause of the PMS-C symptoms. Reactive hypoglycemia is unlikely to be the etiology of PMS-C since it usually is asymptomatic and can be detected in normal women; the symptoms are not relieved by eating and are rarely confined to times when hypoglycemia is likely to be maximal.[2]	• General program. • Low-sugar, low-salt, high-protein diet (five or six small meals/day). • Avoid alcohol and caffeine during the premenstrual period. • Vitamin B_6, vitamin B complex. • Progesterone therapy may be necessary.[2]

The value of diuretics in the treatment of PMS still is controversial, but a smaller number of controlled studies indicate the usefulness of this approach. The usefulness of chlorthalidone, metolazone, furosemide, or spironolactone in conventional dosages during the luteal phase of the cycle has been advocated; spironolactone seems to be favored.[3,42]

Evaluation of the effect of oral contraceptives on PMS is difficult. A few patients report improvement with birth control pills, possibly due to reduction in hormonal fluctuation during the cycle. The more progestogenic pills are associated with fewer PMS symptoms. If no side effects are present and the patient needs contraception, it generally is concluded that this approach is useful. In some patients, symptoms of PMS may be exacerbated.[2]

Bromocriptine (Parlodel®), though used for treatment of all PMS symptoms, offers conflicting results even in well-controlled studies. In general, the drug has proved efficacy in treating breast complaints, but does not help with fluid retention or other symptoms. It probably should be reserved for the PMS patient with an increased prolactin level. If this does not eliminate symptoms, combination with B_6 and progesterone therapy may be necessary.[2]

Antigonadotropin drug, danazol (Danocrine®), has been considered a logical choice for treating PMS. Generally, significant improvements in breast symptoms have been shown with only slight improvement in the other symptoms. Danazol® may be considered for patients in whom other forms of therapy have failed. Because of possible annoying side effects, Danazol® in a dose of 200 mg t.i.d. or q.i.d. should be prescribed in patients who had a combination of PMS and endometriosis and/or fibrocystic breast disease. The patient can remain on this medication for 6 to 12 months.

Some patients may need modification of treatment from time to time. It should be kept in mind that all treatment regimens for PMS remain controversial. Though some drugs certainly are useful in relieving some symptoms, several studies of PMS have shown a strong placebo effect. Unfortunately, the majority of PMS treatment regimens fail to compare drugs used with placebo, consequently, interpretation of the available data is difficult.

LEGAL CONSIDERATIONS

The press focused attention of PMS as a legal defense in 1982 when two European women were acquitted of murder. Currently, the use of PMS as a legal defense, to limit criminal responsibility, is being asserted in several courts in the United States. Presently, in the United States, the only disease process that affords a defense is mental illness. It must be established in most states that the illness was of such a nature to negate or diminish judgmental capacity so that the person did not know right from wrong or had an irresistible impulse to commit the crime. It is arguable that PMS can produce such a result.[46]

To use PMS as a legal defense, three criteria must be met: the court must recognize PMS as an illness; it must be proved that the person suffers from PMS; and the defense must establish a link between the PMS and the crime. At the present time, at least in this country, to meet any of these criteria is not an easy task. Legally, it is difficult to prove that PMS really is a well-established disease, and if it is, whether or not one suffers from it. PMS currently does not fit clearly into a strictly physiological or mental category (insanity plea).[45] Thus, the use of PMS to decrease responsibility for a person's actions still is a moot point.

SUMMARY

Current investigation should enhance our knowledge and understanding about PMS. Whatever cause is suspected, therapy must be individualized for use of one regimen as a "cure-all" usually will be unsuccessful. Patients with PMS no longer may be ignored by the physician; their symptoms should not be dismissed as imaginary or accepted as an unchangeable aspect of being female.

The universal acceptance of PMS as a well-established medical condition, however, could have adverse social, cultural, job-related, and legal ramifications for women and could prevent them from achieving equality. As an accepted legal defense, it could have negative implications for females in custody cases and divorce proceedings and might even justify violence against women (as in plea of self-defense). Several feminist groups are pleased that physicians are taking PMS seriously, but have a growing concern that previous prejudices against women may be resurrected and may prevent equality.[45]

REFERENCES

1. Dalton K: Cyclical criminal acts in premenstrual syndrome. *Lancet* 2:1070, 1980.

2. Lauersen NH, Graves ZR: A new approach to premenstrual syndrome. *Female Patient* 8:41, 1983.

3. Shangold MM: PMS is real, but what can you do about it? *Contemporary Ob/Gyn* 19:251, 1982.

4. Frank R: The hormonal causes of premenstrual tension. *Arch Neurol Psychiatr* 26:1053, 1931.

5. Sweeney J: Menstrual edema. *JAMA* 103:234, 1934.

6. Israel SL: Premenstrual tension. *JAMA* 110:1721, 1938.

7. Thorn G, Nelson K, Thorn D: A study of the mechanism of edema associated with menstruation. *Endocrinology* 22:155, 1938.

8. Greenhill J, Freed S: The mechanism and treatment of premenstrual distress with ammonium chloride. *Endocrinology* 26:529, 1940.

9. Biskind M: Nutritional deficiency in the etiology of menorrhagia, metrorrhagia, cystic mastitis, and premenstrual tension: Treatment with vitamin B complex. *J Clin Endocrinol Metab* 3:227, 1943.

10. Billig G, Spaulding C: Hyperinsulinism of menses. *Industrial Med* 16:336, 1947.

11. Stieglitz E, Kimble S: Premenstrual intoxication. *Am J Med Sci* 218:616, 1949.

12. Morton J: Premenstrual tension. *Am J Obstet Gynecol* 60:343, 1950.

13. Bickers W, Woods M: Premenstrual tension; its relation to abnormal water storage. *N Engl J Med* 245:453, 1951.

14. Greene R, Dalton K: The premenstrual syndrome. *Br Med J* 1:1007, 1953.

15. Rees L: The premenstrual tension syndrome and its treatment. *Br Med J* 1:1014, 1953.

16. Mukherjee C: Premenstrual tension: A critical study of the syndrome. *J Indian Med Assoc* 24:82, 1954.

17. Jones W, Gordon W: Autoimmune progesterone eczema—an endogenous progesterone hypersensitivity. *Arch Dermatol* 99:57, 1969.

18. Farah F, Shbaklu A: Autoimmune progesterone urticaria. *J Allergy Clin Immunol* 48:257, 1971.

19. Reid R, Yen S: Premenstrual syndrome. *Am J Obstet*

Gynecol 139:85, 1981.

20. Abraham G: Premenstrual tension, in *Current Problems in Obstetrics and Gynecology.* Chicago, IL, Yearbook Medical Publishers, 1981, pp 1-39.

21. Backstrom T, Carstensen H: Estrogen and progesterone in plasma in relation to premenstrual tension. *J Steroid Biochem* 5:257, 1974.

22. Briggs M, Briggs M: Relationship between monamine oxidase activity and sex hormone concentration in human blood plasma. *J Reprod Fertil* 29:447, 1972.

23. Holzbauer M, Youdim M: The estrous cycle and monamine oxidase activity. *Br J Pharmacol* 48:600, 1973.

24. Abraham G, Lubran M: Serum and red cell magnesium levels in patients with premenstrual tension. *Am J Clin Nutrition* 34:2364, 1981.

25. Abraham G, Hargrove J: Effect of vitamin B_6 on premenstrual symptomatology in women with premenstrual tension syndrome: A double-blind crossover study. *Infertility* 3:155, 1980.

26. Hargrove J, Abraham G: Effect on vitamin B_6 on infertility in women with the premenstrual tension syndrome. *Infertility* 2:315, 1979.

27. Robinson D: Changes in monamine oxidase and monamines with human development and aging. *Fed Proc* 34:103, 1975.

28. Abraham G, Elsner C, Lucas L: Hormonal and behavioral changes during the menstrual cycle. *Senologia* 3:33, 1978.

29. Klaiber E, Kobayaski Y, Broverman D, et al.: Plasma monamine oxidase activity in regularly menstruating women and in amenorrheic women receiving cyclic treatment with estrogens and progestin. *J Clin Endocrinol* 33:630, 1971.

30. Schwartz U, Abraham G: Corticosterone and aldosterone levels during the menstrual cycle. *Obstet Gynecol* 45:339, 1975.

31. Perrini A, Piliego N: The increases of aldosterone in the premenstrual syndrome. *Minerva Med* 50:2897, 1959.

32. Manlimos FS, Maroulis GB, Abraham GE: Radioimmunoassay of plasma 11-desoxycorticosterone. *Anal Lett* 8:931, 1975.

33. McKenna T, Island D, Nicholson W, et al.: Dopamine inhibits angiotensin stimulated aldosterone biosynthesis in bovine adrenal cells. *J Clin Invest* 64:287, 1979.

34. North R, McCallum R, Contino C, et al.: Tonic dopaminergic suppression of plasma aldosterone. *J Clin Endocrinol Metab* 51:64, 1980.

35. Halbreich U, Assael M, Ben-David M, et al.: Serum-prolactin in women with premenstrual syndrome. *Lancet* 2:654, 1976.

36. Carroll B, Steiner M: The psychobiology of premenstrual dysphoria: The role of prolactin. *Psychoneuroendocrinology* 3:171, 1978.

37. Andersch B, Hahn L, Wendestam C, et al.: Treatment of premenstrual tension syndrome with bromocriptine. *Acta Endocrinol* (suppl 88) 216:165, 1978.

38. Elsner C, Buster J, Schindler R, et al.: Bromocriptine in the treatment of premenstrual tension syndrome. *Obstet Gynecol* 56:723, 1980.

39. DePirro R, Fusco A, Bertoli A, et al.: Insulin receptors during the menstrual cycle in normal women. *J Clin Endocrinol Metab* 47:1387, 1978.

40. Morton J, Addison J, Addison R, et al.: A clinical study of premenstrual tension. *Am J Obstet Gynecol* 65:1182, 1953.

41. Dalton K: *The Premenstrual Syndrome and Progesterone Therapy.* London, William Heinemann Medical Books, Ldt., and Chicago, IL, Year Book Medical Publishers, Inc., 1977.

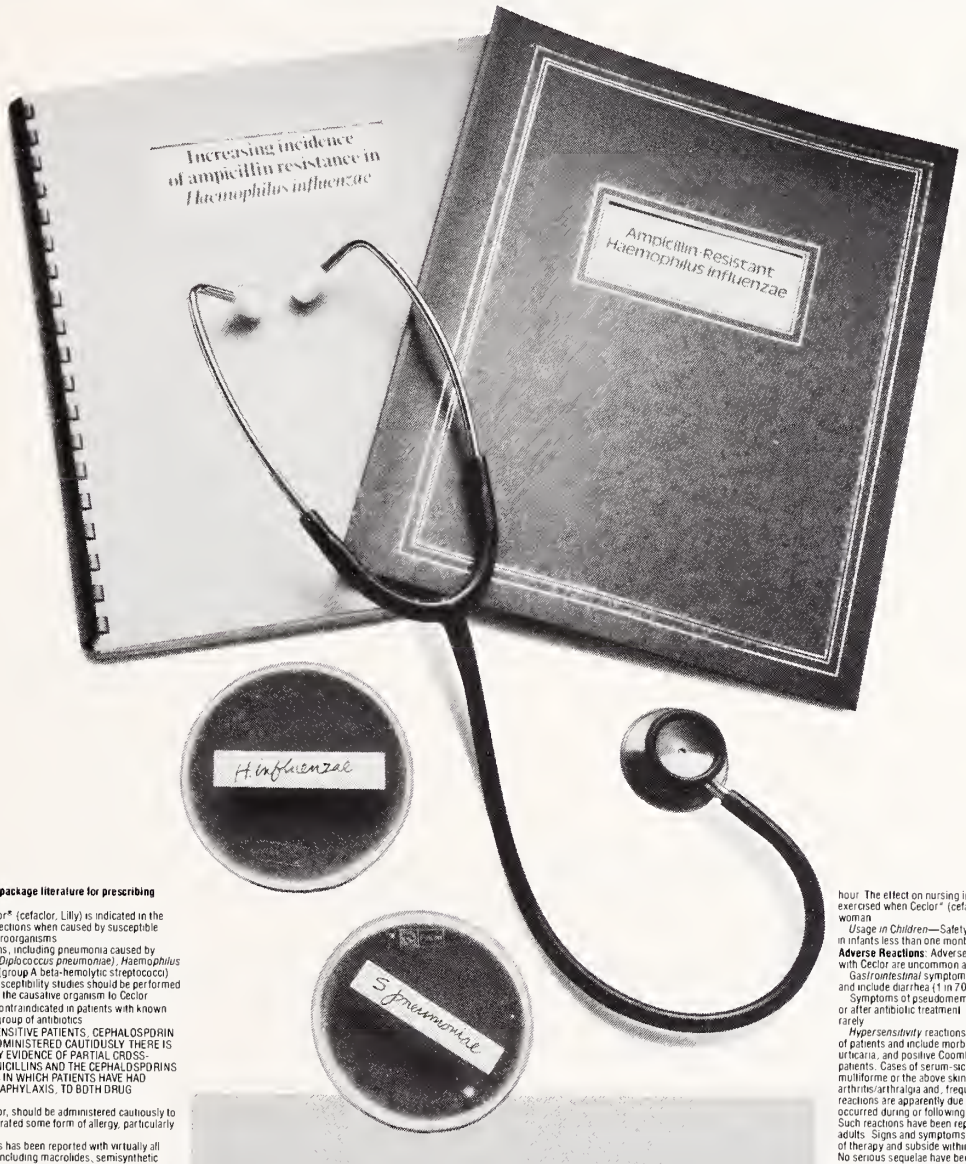
42. Hendler N: Spironolactone for premenstrual syndrome. *Female Patient* 5:17, 1980.

43. Abraham G, Schwartz U, Lubran M: Effect of vitamin B_6 on plasma and red blood cell magnesium levels in premenopausal women. *Ann Clin Lab Sci* 11:333, 1981.

44. Timonen S, Procope B: Premenstrual syndrome and physical exercise. *Acta Obstet Gynecol Scand* 50:331, 1971.

45. Premenstrual syndrome. Is it all in her head? *Sexual Medicine Today* 7:6, 1983.

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms.

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor* (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGDT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.*

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., 8: 91, 1975.
2. Antimicrob. Agents Chemother., 11: 470, 1977.
3. Antimicrob. Agents Chemother., 13: 584, 1978.
4. Antimicrob. Agents Chemother., 12: 490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II:880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., 13: 861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

© 1982, ELI LILLY AND COMPANY

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

300035



Working together.
It can make the difference.

There are certain times when working together helps you accomplish what you couldn't alone.

In the medical profession, it can save lives.

The American Medical Association and your state and county medical societies believe in the value of teamwork — and the necessity of it, in the face of an increasingly complex professional environment.

We also believe that medical societies have certain tasks that the individual physician couldn't possibly assume — and shouldn't have to.

For example, to keep government regulations from interfering with your practice, we effectively represent your interests at local and national levels.

And to keep you up to date on the latest medical advances, we publish JAMA, specialty, state, and county journals.

Why do we believe that teamwork can make such a difference?

Because the very existence of the AMA is solid proof that when physicians work together, they can make their own decisions, protect their own freedoms, and control their own destinies.

And when you have a goal like that, working together makes all the difference in the world.

Join Your Medical Societies Today.

For more information, contact your county or state medical societies, or call the AMA collect at 312/751-6196. Or return the coupon below to your state or county medical society.

☐ Please send me information on AMA, county, and state society membership.

☐ I am a member of my county and state societies; please send me information on joining the AMA.

Name _____

Street _____

City _____ State _____ Zip _____

County _____

Rehabilitation of Cognitive Function in Brain-Damaged Persons

Irwin W. Pollack, M.D., Herbert Kohn, Ph.D., Michael H. Miller, Ph.D., Piscataway*

There has been a growing optimism about the possibility of improving impaired cognitive function in patients who have suffered serious brain injury. Therapeutic activities directed at redeveloping the patient's ability to devise new problem-solving strategies hold the greatest promise.

Recent technological developments in medicine have enabled physicians to keep patients alive who once would have died; yet, this progress is not without a price because many of those who survive are left with permanent disabilities. A significant portion of this group consists of adolescents and young adults who have suffered brain injuries as a result of automobile, motorcycle, or sports accidents.[1]

The magnitude of the problem is reflected in a report on the findings of the National Head and Spinal Cord Injury Survey, from which it is estimated that each year between 30,000 and 50,000 people with serious head injuries are left with physical and intellectual impairments so severe that they are unable to resume their usual activities.[1] From these statistics, it can be estimated that over 1,700 individuals in New Jersey are disabled as a result of a brain injury each year.

Rehabilitation activities for many of these impaired young people are terminated when they are able to walk, communicate, and carry out the ordinary activities of daily living. However, the restoration of these skills always does not enable the patient to resume a productive life because the residual cognitive deficits, which are a product of every serious brain injury, have been left untreated. Until quite recently, impairments in cognitive function were considered to be unmodifiable, a point of view which stemmed from the fact that brain cells once destroyed never are replaced.

Fortunately, the increase in survival rate after brain injury has inspired a reappraisal of the possibilities for restoring effective cognitive function. Over the past two decades, enormous strides have been made in the field of brain physiology and behavioral neurology. Retraining techniques that first were developed to assist stroke patients suffering from memory and language problems have been modified and now are being used in the rehabilitation of individuals who have suffered other types of brain damage, often as a consequence of closed head injuries.[3]

BEHAVIORAL EFFECTS OF CLOSED HEAD INJURIES

When a person strikes his head with great force, the ensuing damage to the brain is not limited to the point of impact. Remote parts of the brain are involved as well. Closed head injuries are the product of several forces in addition to the impact itself; especially significant is the sudden violent deceleration and rotation which leads to twisting of the brain on the brain stem. This causes a shearing and tearing of nerve fibers in the ascending reticular tracts of the brain stem which, with the accompanying edema, is responsible first for coma and later in the recovery process for a subnormal level of alertness.[4]

*From the Department of Psychiatry, UMDNJ-Rutgers Medical School. Correspondence may be addressed to Dr. Pollack, UMDNJ-Rutgers Medical School, Piscataway, NJ 08854.

Damage to the cerebral cortex itself usually is expressed behaviorally in two ways. The first type of deficit behaviors is related to specific functions of the particular areas of the brain that have been injured. These localized effects of brain injury include paralysis, visual field defects, difficulty in understanding and expressing oneself in spoken and written language, and problems in organizing personal and external space.

The second type of deficit cannot be attributed to a disruption of the function of a specific brain area, but appears to be related to the generalized disruptive effect which any major injury has on brain function. One of the behavioral consequences of this nonspecific impairment of function is a decrease in the ability to focus and sustain attention to a task; hence, many individuals who have suffered a closed head injury are distracted easily. In addition, both cognitive and motor activities markedly are slowed and many patients exhibit a reduced ability to process information at normal rates. Because the brain-injured patient frequently receives more information than he can handle easily, he tends to respond to the most obvious aspect of the situation while disregarding the context in which it is embedded. Another frequent consequence of serious brain injury is a loss of initiative and a reduction in social competence. To family members, this often is the most disrupting of all the patient's problems. Many are described as less mature, intrusive, childlike, and generally "out of step." As a result, old friends who may have demonstrated a sympathetic interest during the patient's "sick phase" gradually drift away. Loneliness often is the most tragic aftermath of a serious brain injury.[5]

COGNITIVE REHABILITATION: THE CONCEPT

Cognitive rehabilitation programs start where the traditional therapies which concentrate primarily on improving physical and language abilities leave off. Retraining efforts are aimed at improving the impaired cognitive functions by using techniques which take advantage of the gains already made in these areas and, when possible, by circumventing the remaining deficits. Emphasis is placed upon the development of new problem-solving strategies rather than on rebuilding lost skills because the ability to transfer skills from one situation to another greatly is reduced after brain injury. For example, a patient might become quite proficient in duplicating complex geometric patterns using groups of colored blocks but this skill does not enhance the individual's ability to manipulate other objects in space nor does it assist him to find his way home from the hospital. On the other hand, by their very nature, strategies can serve the individual in a number of situations without requiring him to rearrange or to reorganize his approach to solving a problem.

Retraining exercises are designed to simulate "real world" situations. They provide the patient with a structure within which he can work to improve his ability to pay attention, to remember, and to organize and integrate information of various kinds. In each exercise, the patient is confronted with a task to be carried out and is encouraged to master it. When he succeeds, he is rewarded with praise and then he proceeds to the next task. If he fails to respond effectively, he is given sufficient cues by the therapist so that, with the additional information, he is able to complete the task. When the patient is able to work through a retraining exercise consistently without assistance from the therapist, he is considered to have developed a usable strategy and a new, more complex set of tasks is presented to him.

Since each person has a unique learning style, it is impossible to know beforehand which particular problem-solving strategy will be best for a given individual. Therefore, each person is given the opportunity to work on a predetermined set of training exercises under the close observation of the therapist. Gradually, out of this shared experience, the most effective strategy for carrying out each task evolves. The exercises are presented in a step-wise progression moving from simple to more complex. Each one is designed to make the patient aware of his cognitive deficits while at the same time providing him with a vehicle through which he can develop a more effective problem-solving strategy. The patient always is an active participant in the process. The therapist, in turn, is responsible for providing the patient with immediate and specific feedback.[6-7]

PATIENT SELECTION: WHO CAN PROFIT?

Each brain-injured patient's potential for improved cognitive function depends on the ability to build upon his preserved areas of competence. Therefore, the proper assessment of the patient's postinjury cognitive function requires that the rehabilitation staff obtain a detailed history of his preinjury/experience with special emphasis on the level of previous school and job performance.

Our experience has shown that in order to benefit from a cognitive retraining program such as the one described above, a patient should have a minimum postinjury I.Q. of 80 and should be able to communicate in simple spoken and written language. Furthermore, he should be free of any emotional disorder which would interfere with his full participation in the rehabilitation activities. Ideally, the patient should recognize that he has more difficulty learning than he had before his injury but he need not be aware of the exact nature of his deficits. In fact, the thrust of the rehabilitation program is directed toward helping the patient to recognize both his residual deficits and his remaining assets. In most cases, the patient's physical disabilities are not a limiting factor in the cognitive retraining process.

OUTCOME ASSESSMENT

The problems which are encountered in evaluating the results of cognitive retraining are signficant. They are rooted, in part, in the absence of documentation relating to preinjury events and behaviors which could provide information pertinent to an individual's potential for rehabilitation. Unfortunately, valid preinjury test results rarely are available. School group intelligence and achievement tests are of little value in assessing an individual's abilities and potential unless they are repeated at regular intervals over a number of years. School grades, if they are consistent, are a better indicator of preinjury cognitive ability than are

isolated test results.

Frequently, there is a failure to screen for such preinjury conditions as alcoholism and drug abuse which compromise cognitive efficiency. The absence of this kind of information also limits the value of outcome studies.[8]

Heterogeneity in the type and severity of the brain damage presents yet another problem. It would be accurate to say that no two individuals are injured in the same way. Improved x-ray techniques provide some help, but, frequently, the degree of cognitive impairment experienced after a head injury is unrelated to the extent of the visualized damage. Finally, every outcome study must allow for the fact that most individuals who have suffered a brain injury show spontaneous improvement in their physical condition, language abilities, and cognitive functions. Usually, the most significant gain occurs during the first 6 to 12 months following the injury. Although additional gains in cognitive function have been recorded well beyond the second postinjury year, the rate of improvement markedly is attenuated.

Despite the difficulties inherent in evaluating changes in cognitive function after a brain injury, the evidence supporting the effectiveness of systematic retraining is substanial.[3,6,9]

THE RUTGERS MEDICAL SCHOOL PROGRAM

The Rutgers Medical School Cognitive Rehabilitation Program is divided into four retraining units. The first consists of a series of exercises designed to improve the patient's ability to focus and to sustain attention. Examples of these exercises include one in which the patient is required to play a video game while he converses with the therapist, answers specific questions, or works on simple arithmetic problems. Another requires the patient to observe a colored light as it moves around the circumference of the circle and to signal the therapist when it arrives at predetermined points along the pathway.

The second training unit is designed to help the patient to increase the amount of information he is able to process in a given time period. Training exercises in this unit provide the individual with practice in sequencing, grouping, categorizing, and summarizing information. For example, the patient is given a newspaper article to read and he is instructed to write out the most significant information contained in it. From this material he develops a summary and finally constructs a representative headline.

The third retraining unit consists of exercises designed to help the patient to develop strategies that he can use for solving problems. In a typical exercise, the therapist provides background information from which the patient is required to develop a logical sequence of questions. In order to be acceptable, a question must be based only on the available information and the answer must add relevant new data to the information base. The new information, thus obtained, is integrated with the previously acquired and, if necessary, the whole is reorganized. From this new data base, the next appropriate question is developed. When the patient believes that he understands the nature of the problem, he is asked to propose a solution, preferably one which involves a compromise acceptable to both parties.

The fourth training unit employs exercises which provide the patient with an opportunity to enhance his ability to communicate effectively. Each exercise gives the patient an opportunity to express himself in words and in actions. As a participant observer, he learns to hear and to consider another person's viewpoint. Each exercise is videotaped and is played back to the group immediately so that it can be reviewed while the impressions are still vivid.

In addition to the formal cognitive retraining exercises, patients participate in carefully chosen recreational activities and in social functions which they help plan. The need for the patient to think through each activity is emphasized in all segments of the rehabilitation program.

There are enormous stresses on the family of a brain-injured person. Usual family interrelationships are disrupted. In order to be available to care for the patient, parents are required to modify their lives and plans for the future. Frequently, younger siblings are recruited to assume part of the caretaking responsibilities for an older cognitive-impaired brother or sister who continues to demand the rights of seniority. For these reasons, tension between the patient and siblings often is intense. In order to assist the family to maintain a reasonable balance, routine counseling sessions are provided by the members of the rehabilitation staff.

The staff of the Rutgers Medical School Program has endeavored to minimize the influence of many of the factors which in the past have complicated the evaluation of program effectiveness. For example, when criteria enumerated in the Glasgow Coma Scale are applied, all but 2 of the 13 patients who were accepted for retraining had experienced a period of coma exceeding ten days. Coma which exceeds one week in duration generally is recognized as indicating that a severe brain injury has occurred and that the prognosis for spontaneous recovery of effective cognitive functioning is poor.[10] Further, 11 of the 13 patients admitted to the program had experienced brain injury at least 12 months before the onset of their rehabilitation activity, so that it can be assumed that the spontaneous recovery of function contributes only a small amount to the observed cognitive gains.

Finally, the cognitive retraining exercises do not employ materials taken from the tests which are used to evaluate patient progress. Because of this, the effect of practice on the test results is reduced. However, because each patient is retested at regular intervals, there is no way to eliminate all practice effects.

Although most of the patients in the Rutgers Medical School Program still are actively involved in their retraining activities, retesting after a period of 13 weeks (39 therapeutic sessions) showed a pattern of improvement which was remarkably uniform. Certain subtests of the Halstead-Reitan Battery, one of the two test batteries which regularly are used to evaluate patient progress, showed significant positive changes. These subtests (the Trail Making Test, the Category Test, and the Tactual Performance Test) evaluate the patient's ability to process nonverbal information as well as the ability to recognize inherent relationships among pieces of information within categories. An in-

dividual's performance on these subtests also reflects the ability to be flexible in the approach to problem solving. The ability to recognize the relationship between discreet pieces of information is necessary if learning is to take place. In addition to showing greater competence on these Halstead-Reitan subtests, most of the patients also improved their performance on certain subtests of the Wechsler Adult Intelligence Scales, the other test battery used routinely to evaluate patient progress. This battery, which is subdivided into a group of verbal tests and a group of performance tests, has been used more frequently than any other to evaluate the changes in cognitive function which occur following a brain injury. Improvement early in the rehabilitation process most commonly is seen on performance tasks; however, these results must be interpreted cautiously since several subtests in the Performance Scale are among those most subject to practice effects. After 13 weeks in a retraining program, our patients showed gains in performance I.Q. ranging from 0 to 20 points with an average gain of 8 I.Q. points.

Although better test performance is an important indicator of improved cognitive function, test results alone, no matter how reliable, mean little if the patient is unable to return to school, cannot hold a job, and has no social life. Some of the earliest indicators of improving cognitive ability are reflected in changes in the patient's attitude rather than in improved intellectual function. Family members frequently refer to the patient's growing interest in the affairs of the family. A slowly developing curiosity about events which are occurring outside of the home also have been reported. The patient also may show an increase in initiative that leads him to assert himself more. This new forcefulness can bring him into conflict with other family members. As the therapeutic process continues, patients often seem less self-involved, less concrete, and more appropriate in their relationships to others. During the final stages of the rehabilitation process individuals seem better able to recognize both their cognitive strengths and remaining deficits.

CASE REPORT 1

A 21-year-old white male university student, was injured in a motor vehicle accident in March 1980. He was thrown from the car striking the left side of his head. Examination at the time of admission to the hospital revealed a young man with a markedly reduced level of consciousness who had a right hemiplegia, a fracture of the left wrist, and multiple lacerations. A computed tomographic brain scan showed a left parietal lobe intracerebral hemorrhage. On the tenth postaccident day, the patient began to respond regularly to verbal stimulation. Over the next two weeks he became progressively more alert and responsive although he remained confused and had poor short-term memory.

Seventeen days after the accident, the patient was transferred to a rehabilitation hospital for continued care where he remained for approximately five months. He was discharged from the hospital to his parent's home in August 1980. Although he had made significant gains, some physical deficits remained including a residual right-sided weakness and reduced tactile discrimination ability. His attention span and short-term memory had improved signficantly, but he still had difficulty organizing and integrating information and in separating relevant from irrelevant data. In addition, both motor activity and cognitive processing were significantly slowed. He was able to behave appropriately in social situations but he still showed signs of immaturity.

During the following year he lived at home and received outpatient physical therapy and speech therapy. In September 1981, the patient returned to the university against the advice of his parents who felt he was not yet ready. By the end of the fall semester, he was failing in almost every course. He returned to the university for the second semester in January 1982, but after a brief period he saw the impossibility of his situation and elected to return home. It was at this point that he applied for admission to the Rutgers Medical School Cognitive Rehabilitation Program.

In February 1982, a preadmission neuropsychological examination showed that the patient had significant residual problems in organizing information and in carrying out more than one mental operation at the same time. When he was confronted with more information than he could easily manage, he reverted to a literal interpretation of the material. In addition, he showed a reduced sensitivity in social situations and had a limited ability to monitor cues given by others. On the Wechsler Adult Intelligence Scale, he had a full scale I.Q. of 106, a verbal I.Q. of 114, and a performance I.Q. of 94. Although no preinjury intelligence test scores were available for comparison, the patient's college admission test scores and high school grades placed him in the 98th percentile of college-bound high-school seniors. Taken together, this information strongly suggests that he had a preinjury I.Q. in the range of 125 to 135.

The patient began his cognitive rehabilitation program early in March 1982. He regularly attended three two-and-one-half hour therapy sessions each week for a period of 36 weeks. In the fall of 1982, he registered for two college level courses which he successfully completed in January 1983. The complete neuropsychological battery was readministered in December 1982 at the end of 36 weeks in the program. The results showed improvement in tactile discrimination and information processing. On the Wechsler Adult Intelligence Scale, his posttherapy verbal I.Q. was 127, his performance I.Q. was 108, and his full scale I.Q. was 120. Reports from the patient's family indicated that though there was some improvement in his ability to handle social situations, he was still somewhat immature and had made few new friends. Much of his time was spent alone studying for his courses.

CASE REPORT 2

The patient, a 23-year-old white female, was injured in a motor vehicle accident in March 1979. She was thrown from the car and struck the left side of her head. Neurological examination revealed evidence of a significant contrecoup injury to the right parietal-occipital area. At the time of her admission to the hospital she was unresponsive to all stimulation. Over the following two weeks, her coma lightened but she continued to show fluctuating levels of alertness. After

three weeks, the patient was transferred to a rehabilitation hospital where she remained until July 1979. An electroencephalogram in May 1979 demonstrated a bilateral spike and slow wave pattern most prominent over the right frontal area. As a precautionary measure, she was placed on phenobarbitol 30 mg b.i.d.

Although the patient made remarkable progress while in the rehabilitation hospital, she was left with some residual deficits. There was a minimal left-sided weakness and a persisting left visual field defect. More troubling were the remaining cognitive deficits which included reduced auditory and visual memory, slow information processing, and word finding difficulties. She also had a limited ability to carry out two mental activities simultaneously, e.g. listening and writing notes. She showed little initiative and her level of social competence was reduced markedly. All motor and cognitive activities were performed quite slowly.

By October 1979, the patient was able to return to the part-time clerical job she had held prior to her injury. In addition, she reenrolled as a part-time student in the school of business which she had been attending at the time of her accident. Because of her continuing cognitive problems, she was unable to manage her secretarial courses and transferred to a less demanding clerical curriculum which she managed to complete despite the fact that she was severely hampered by her slow response rates. At the time of her admission to the Rutgers Medical School Cognitive Rehabilitation Program in December 1981, she still was working part-time at her clerical job. In an evaluation of the patient's job performance, a supervisor noted that she was a pleasant and dedicated worker who was functioning adequately, if not entirely competently. During the preadmission interview, the patient stated that she was seeking help because she could not remember how to carry out certain job procedures. Her parents expressed concern because she had lost many of her old friends and had shown little initiative in making new ones. In addition, they stated that she seemed uninterested in many of the activities that had occupied her profitably prior to her injury.

A preadmission neuropsychological evaluation in December 1981 showed significant residual impairments in cognitive function. The patient's deficits included a reduced ability to focus and sustain attention. The resultant heightened distractability caused her to have difficulties controlling the inflow of information. Even after she had identified relevant pieces of information, she was quite slow in organizing them. In addition, she appeared to be socially immature and showed little spontaneity. On the Wechsler Adult Intelligence Scale, she obtained a verbal I.Q. of 92, a performance I.Q. of 91, and a full scale I.Q. of 91. Although the patient had never been an excellent student, her average high school grades had been in the B to C range; these I.Q. test results clearly represented a drop from her preinjury level of intelligence.

The patient completed her cognitive rehabilitation program in June 1982 approximately seven months after her admission. The complete neuropsychological battery was administered again and the results showed improvement both in verbal and performance areas of function. The verbal I.Q. was 99, her performance I.Q. 107, and her full scale I.Q. was 102. The patient was able to process greater amounts of information effectively and showed significant improvement in her ability to manage abstract concepts. In his latest report, her supervisor at work had given her a competent performance evaluation and she had been offered the opportunity to work additional hours. Her parents reported that she was more organized in her activities at home and that she was becoming more adept in social situations. Further evidence of her progress was the fact that, with the encouragement of her family, she successfully pursued a course of study in the local center for adult education. As far as her parents are concerned, the patient's major remaining problem is her continuing lack of initiative.

COMMENT AND CONCLUSION

These cases effectively show that it is possible to improve cognitive function through retraining activities carried on over an extended time period. Both of these patients not only improved their test performance, but also were able to return to their preinjury occupations. Both have made slower progress in reestablishing peer relationships, a fact which has been noted by others who work with cognitively impaired individuals.[10] Apparently, these patients lack the initiative to use their leisure time effectively.

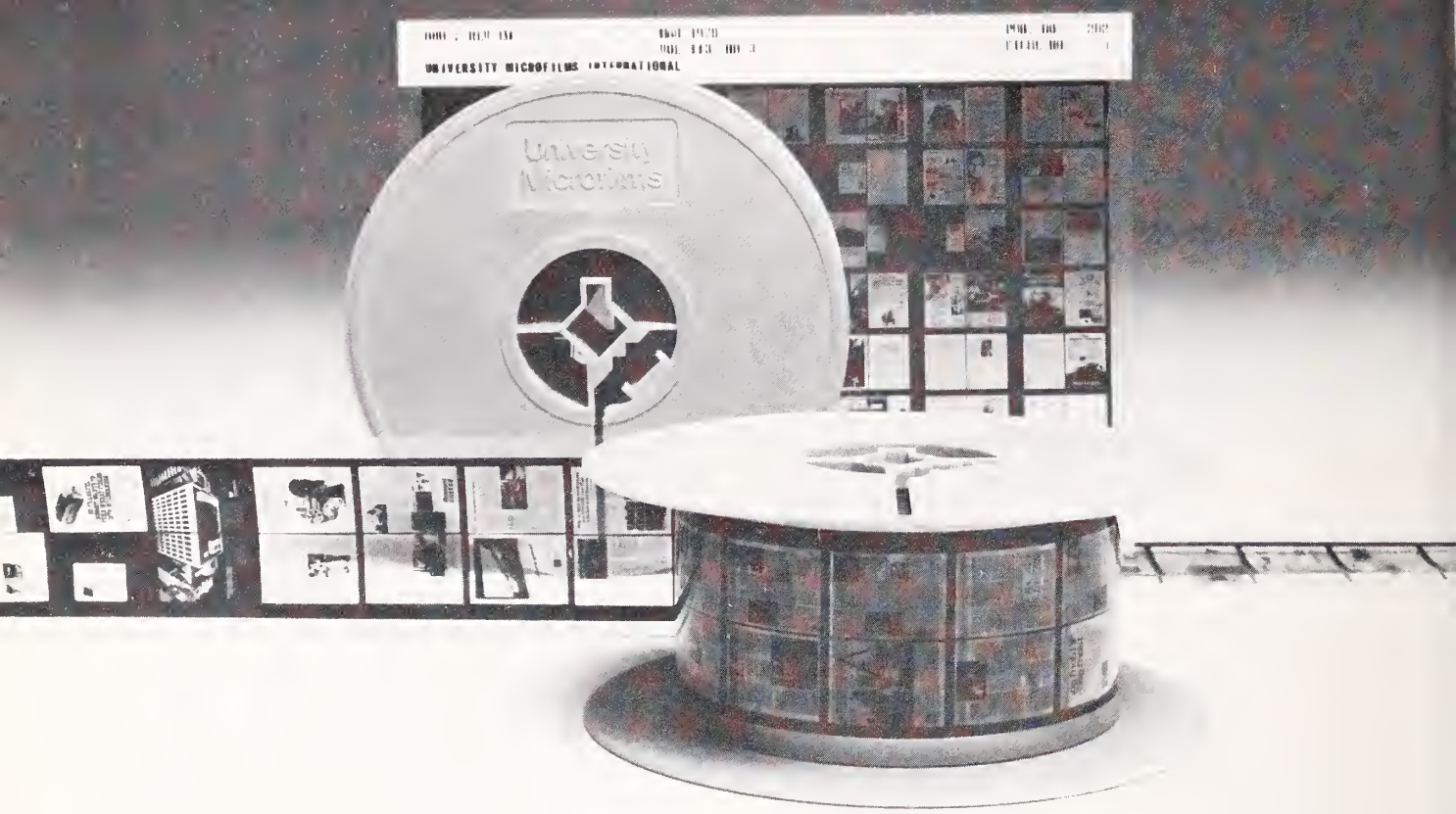
Long-term followup studies have demonstrated that the patient's social isolation and reduced participation in leisure activities persist even after he has recovered sufficiently to return to a job. Many of the patients who were interviewed reported that they were very lonely. These findings emphasize the fact that a cognitive rehabilitation program cannot be truly effective unless it successfully assists its clients to reestablish a satisfying lifestyle.

Jannett urges us to remember that "the tremendous efforts expended on extensive treatment in the early weeks after injury often are largely wasted by the failure to provide the means whereby the full potential for recovery can be achieved during the later stages."[11]

REFERENCES

1. Kalsbeck WD, et al.: The national head and spinal cord injury survey: Major findings. *J. Neurosurg* 53:19-31, 1980.
2. Diller L: Psychomotor and vocational rehabilitation, in Benton AL (ed): *Behavioral Change in Cerebrovascular Disease*. New York, NY, Harper and Row, 1970, pp. 81-105.
3. Lezak MD: *Neuropsychological Assessment 2nd Ed.* New York, NY, Oxford University Press, 1983, pp. 167-169.
4. Weddell R, et al.: Social adjustment after rehabilitation: A two-year followup of patients with severe head injury. *Psychol Med* 10:257-263, 1980.
5. Ben-Yishay Y: Working approaches to remediation of cognitive deficits in brain damage. *IRM Behavior Science, Rehabilitation Monograph:* 61, 1980.
6. Ben-Yishay Y: Working approaches to remediation of cognitive deficits in brain damage. *IRM Behavior Science, Rehabilitation Monograph:* 62, 1981.
7. Levin H, et al.: *Neurobehavioral Consequences of Closed Head Injuries*. New York, NY, Oxford University Press, 1981, pp. 208-215.
8. Gianutsos R, Gianutsos J: Rehabilitating the verbal recall of brain-injured patients by mnemonic training: *Clin Neuropsy* 1:117-135, 1979.
9. Jennett B, Plum F: Outcome after severe brain damage: A practical scale. *Lancet I:* 480-483, 1975.
10. Oddy M, et al.: Subjective impairment and social recovery after closed head injury. *J Neurolol Neurosurg Psychiatry* 41:611-616, 1978.
11. Jennett B: Who cares for head injuries? *Br Med J* 3:267-270, 1975.

This publication is available in microform.



University Microfilms International

Please send additional information for _____
(name of publication)

Name _____

Institution _____

Street _____

City _____

State _____ Zip _____

300 North Zeeb Road
Dept. P.R.
Ann Arbor, Mi. 48106
U.S.A.

30-32 Mortimer Street
Dept. P.R.
London W1N 7RA
England

Case Report: Tuberculous Abscess of the Spleen

William E. Farrer, M.D., and Suresh Ramamurti, M.D., Elizabeth*

A male with subacute febrile systemic illness was found to have a solitary abscess of the spleen caused by* Mycobacterium tuberculosis. *Splenic abscess is a relatively rare condition and causes difficulty in diagnosis. Localized tuberculosis of the spleen is rarer and diagnosis often is delayed.

Isolated splenic abscess is uncommon. A recent review from Cleveland Metropolitan Hospitals revealed only 10 cases in an 11-year period (0.11 percent of admissions and 0.22 percent of autopsies)[1] and 14 cases were seen at the University of Louisville Associated Hospitals over an 18-year period.[2] The high reported mortality rate, even in the antibiotic era,[2] and the frequency of diagnosis only at postmortem examination stress the difficulty in diagnosis and treatment of this condition. Although a wide range of organisms have been reported to cause splenic abscesses,[1] *Mycobacterium tuberculosis* is an extremely rare etiologic agent of isolated splenic abscess, especially in recent years. Our report concerns a patient who was successfully treated for tuberculous abscess of the spleen.

CASE REPORT

A 48-year-old black male was admitted to St. Elizabeth Hospital on November 2, 1981, with a several month history of fever, chills, night sweats, headaches, and anorexia. He also complained of pleuritic left chest and upper arm pain, mild left upper quadrant pain, and early satiety. He had no significant recent travel, but while in the Army from 1952 to 1963 he traveled worldwide. He had pneumonia in 1952 but had no history of tuberculous infection or exposure. There was heavy alcohol intake until three years prior to admission and a 35 pack-year smoking history.

Initial physical examination revealed no fever or other abnormalities.

Laboratory data were unremarkable, except for sedimentation rate of 87 and alkaline phosphatase of 163 U/L (normal to 115 U/L). Hemoglobin was 13 gm/DL and white count 8,000. SGOT was 35 U/L (normal to 40 U/L). Bone, liver-spleen, and gallium scans and upper gastrointestinal series with small bowel follow-through were interpreted as normal, as was the chest x-ray. Multiple blood cultures were negative. T_3 and T_4 were normal. 5 TU PPD produced 20 mm of induration at 48 hours. The CT scan of the abdomen (Figure 1) showed a large septated cold area in an enlarged spleen. In retrospect the liver-spleen and gallium scans also were abnormal.

The patient underwent splenectomy on November 16, 1981, and the spleen was found to be three times normal size, adherent to the diaphragm and to the retroperitoneal surface, with a large abscess. There also were enlarged retroperitoneal lymph nodes; the liver appeared normal. The spleen weighed 720 gm and consisted mostly of necrotic material. Pathology showed stellate suppurative abscesses and granulomatous inflammation with Langerhans' cells and

*From the Division of Infectious Diseases, Department of Medicine, St. Elizabeth Hospital. Correspondence may be addressed to Dr. Farrer, St. Elizabeth Hospital, 225 Williamson Street, Elizabeth, NJ 07207.

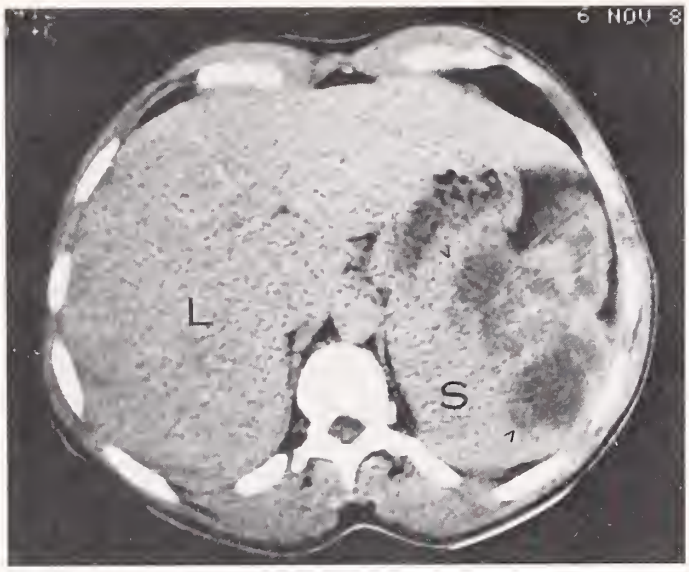


Figure 1—Computerized tomography of abdomen showing septated abscesses in spleen (arrowheads). L:liver; S:spleen.

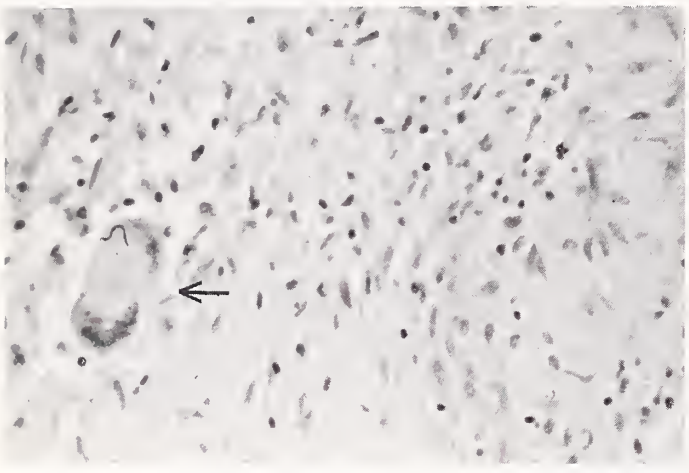


Figure 2—Section of splenic abscess showing granuloma formation. Arrow denotes Langerhans' giant cell. Hematoxylin-eosin; magnification 400X.

other giant cells (Figure 2). A liver biopsy revealed nonspecific triaditis but no granulomata; a lymph node had chronic lymphadenitis with focally necrotic granulomata. Acidfast bacillus (AFB) and fungal stains were negative.

Postoperatively, the patient had a transient fever to 101.5° but defervesced without antibiotic treatment. Routine cultures were negative and the patient was discharged on November 29, 1981, on no treatment.

He felt well until one month later when he had recrudescence of fever, chills, and sweats, with increasing abdominal girth but no abdominal pain. He was empirically treated with ampicillin, but showed no response and was readmitted on January 7, 1982. At this time, physical examination revealed an ill-looking black male in no acute distress. Temperature was 101.5. Abdomen had evidence of ascites, but no rebound or masses. White blood count was 11,000 with 49 polys, 12 bands, 29 lymphs; hemoglobin was 14.7 gm/DL. Chest x-ray was negative. Alkaline phosphatase was 126 U/L; SGOT, 66 U/L. An abdominal paracentesis yielded 500 ml of amber-colored fluid. No cell counts or chemistries were performed, but the gram and AFB stains were negative as were routine cultures.

At this point, the cultures of the splenic abscess on Lowenstein-Jensen media were noted to be positive for AFB. The patient was started on isoniazid 300 mg/day, rifampin 600 mg/day, and ethambutol 15 mg/kg/day, and defervesced within 5 days. He has remained well with an increasing sense of well-being, weight gain, and resolution of the ascites. The organism was identified by the New Jersey State Mycobacteriology Laboratories as *Mycobacterium tuberculosis* sensitive to isoniazid, rifampin, and ethambutol.

DISCUSSION

The difficulty in establishing the diagnosis of splenic abscess and the further delay in recognizing the tuberculous nature of the infection are characteristic of these conditions. Clinical clues to splenic abscess may be subtle. Fever usually is present, but often is intermittent. Abdominal pain may be variable and complaints of left-sided chest pain or arm pain may divert attention from the abdomen.

X-rays of the abdomen and barium contrast studies are helpful if they demonstrate a soft tissue mass, extragastric left upper quadrant gas, or displacement of stomach or splenic flexure. They may be nondiagnostic, however. Chest x-ray may show elevated left hemidiaphragm and/or left pleural effusion, but this is nonspecific.[2]

Radionuclide studies have an increased diagnostic yield for splenic abscess but still have difficulties. ^{99m}Technetium scans often will show a lesion, but false negative scans have been reported.[2-4] Gallium scan can be falsely negative due to masking by surrounding normal tissue[3] or nonspecific due to generalized increased uptake in the setting of sepsis.[4] ^{67}Gallium scanning has been proposed as a simple and reliable screening tool for extrapulmonary tuberculosis.[5] In our patient, however, the gallium scan showed very subtle changes noted only in retrospect.

Ultrasonography[6,7] and computed tomographic (CT) scanning[4] are more sensitive and specific and can give anatomic detail. These techniques have not only increased diagnostic accuracy in splenic abscess but have even permitted percutaneous drainage.

The most common organisms isolated from splenic abscesses are *Staphylococcus aureus*, various streptococci, gram-negative bacilli, and *Mycobacterium tuberculosis*. Other organisms occasionally are reported.[1]

In the prechemotherapy era, tuberculous involvement of the spleen was not so rare. Early authors differentiated primary tuberculosis of the spleen, in which the disease process is localized to the spleen, from secondary tuberculosis.[8-10] The latter is associated with active tuberculosis in other organs, such as peritonitis,[11] or disseminated tuberculosis. They pointed out that while the spleen is not the portal of entry or even the first site of active tuberculosis in primary tuberculosis of the spleen, the spleen can act as the focus for dissemination of the disease while the original focus may heal entirely. Winternitz reported a case and reviewed 50 previous reports of primary tuberculosis of the spleen.[8] He noted that the disease could be chronic and many patients did not have anemia or leukocytosis; only a small percentage of cases had definite abscess formation. In 1933, Shands[10] reported 3 cases of primary splenic tubercu-

losis, 1 case with abscess; Rumold and Orr [9] reported a case of splenic tuberculous abscess. Very few cases of primary splenic tuberculosis and even fewer of solitary tuberculous abscess of the spleen have been reported since the introduction of effective chemotherapy and these not always have been documented properly.[12-15]

This patient seems to have had primary tuberculosis of the spleen. His chest x-ray and CT of the chest showed no evidence of active or past tuberculosis. At laparotomy, there was no hepatic or generalized peritoneal involvement. Postoperative development of ascites probably represented tuberculous peritonitis from local seeding at the time of surgery with rapid therapeutic response to appropriate antituberculous medication. In retrospect, the positive PPD with granulomata in the resected spleen and draining lymph nodes, albeit atypical, should have prompted earlier therapy.

The origin of splenic abscess in our patient is unknown. The spleen may have been seeded hematogenously at some remote time and disease reactivated after other evidence of disease had resolved. Lack of apparent intrathoracic involvement makes direct extension through the diaphragm unlikely and there was no other intra-abdominal involvement noted at the time of surgery.

As tuberculosis becomes increasingly uncommon in our society, the chance of missing a diagnosis of extrapulmonary tuberculosis increases. Long delays in diagnosis are common in such conditions as tuberculous meningitis,[16] peritonitis,[11, 17] enteritis,[17, 18] and spondylitis.[19] Tuberculosis should be considered as a cause of splenic abscess. Left upper quadrant symptom and signs and the presence of a positive PPD should prompt investigation.

REFERENCES

1. Chulay JD, Lankerani MR: Splenic abscess: Report of 10 cases and review of the literature. *Am J Med* 161: 513-522, 1976.
2. Chun CH, Raff MJ, Contreras L, et al.: Splenic abscess. *Medicine* 59: 50-65, 1980.
3. Simson JNL: Solitary abscess of the spleen. *Br J Surg* 67: 106-110, 1980.
4. Baruch J, Levy Y, Brook JG, Kleinhaus U, et al.: Splenic abscess diagnosed with the aid of abdominal CT: Report of two cases. *Br J Surg* 68: 37-138, 1981.
5. Sarkar SJ, Ravikrishnan KP, Woodbury DH, et al.: Gallium—67 citrate scanning—a new adjuct in the detection and followup of extrapulmonary tuberculosis. *J Nucl Med* 20: 833-836, 1979.
6. Pawar S, Kay CJ, Gonzalez R, et al.: Sonography of splenic abscess. *AJR* 138: 259-262, 1982.
7. Ralls PW, Quinn MF, Colleti P, et al.: Sonography of pyogenic splenic abscess. *AJR* 138: 523-525, 1982.
8. Winternitz MC: Tuberculosis of the spleen. *Arch Intern Med* 9: 680-697, 1912.
9. Rumold MJ, Orr JG: Tuberculosis abscess of the spleen. *Ann Surg* 98: 474-477, 1933.
10. Shands MR: Chronic primary tuberculosis of the spleen. *Am J Surg* 20: 707-721, 1933.
11. Dineen P, Homan WP, Grafe WR: Tuberculous peritonitis: 43 years experience in diagnosis and treatment. *Ann Surg* 184: 717-722, 1976.
12. McGowan WB: Primary tuberculosis of the spleen. *Cent Afr J Med* 11: 39-40, 1965.
13. Fung WP, Siew CO, Lee YS: Splenic tuberculosis presenting as pyrexia of unknown origin. *Med J Austr* 1: 446-448, 1973.
14. Paris J, Ribet M, L'Hermaine C, et al.: Abscés froids tuberculeux de la rate au cours d'une biharziose hépato-intestinale Evolutive. *Sem Hop Paris* 52: 1870-1872, 1976.
15. Cummings Y, Cruz I, Rovi J, et al.: Primary splenic tuberculosis in transplant candidates. *JNMA* 70: 167-169, 1978.
16. Swart S, Briggs RS, Millac PA: Tuberculous meningitis in Asian patients. *Lancet* 2: 15-16, 1981.
17. Sherman S, Rohwedder JJ, Ravikrishnan KP, et al.: Tuberculous enteritis and peritonitis: Report of 36 general hospital cases. *Arch Intern Med* 140: 506-508, 1980.
18. Tabrisky J, Linstrom RR, Peters R, et al.: Tuberculous enteritis, review of a protean disease. *Am J Gastroenterol* 63: 49-57, 1975.
19. Marcq M, Sharma OP: Tuberculosis of the spine: A reminder. *Chest* 63: 403-408, 1973.

Case Report: Intrauterine Testicular Torsion

Joel Rosenberg, M.D., and Milton Zimmerman, M.D., Clifton*

Torsion of the testicle can occur in utero. The diagnosis is made by physical examination in the newborn. Surgical intervention is the treatment, although the affected testicle uniformly is nonsalvageable. The contralateral testicle almost invariably is normal but surgical repair to prevent torsion is recommended.

Torsion of the testicle can occur in utero and despite the relative paucity of case reports, it is a fairly common condition although the exact incidence has not been defined.

CASE REPORT

Our patient was a full-term, 6-pound, 4-ounce male, Apgar 9, born to healthy parents. At birth, physical examination revealed the left hemiscrotum to be swollen. The testicle was enlarged, rock hard, and purple in color through the skin. Palpation of the organ caused the baby no apparent discomfort. The mass did not transilluminate. The contralateral testis was normal.

A technetium scan was performed, but this was difficult to interpret and deemed nondiagnostic.

When the baby was four days old, we performed surgical exploration of the scrotum and removed the testicle. The pathology report indicated complete infarction with areas of calcification (Figures 1 and 2).

The postoperative course was uneventful and, in fact, the baby went home the next day. He continues to thrive.

DISCUSSION

There are approximately 100 similar case reports in the literature; none of them represents a significantly large series.[1] Diagnosis is fairly simple by physical examination alone, but technetium scanning is recommended.[2,3] The differential diagnosis includes tumor (yolk sac), hematocele, and other rare entities.[4]

The role of surgery unquestionably has been established as all the possibilities included in the differential diagnosis require surgical therapy. However, the testicular salvage rate is so abysmal that surgical intervention need not be on an emergency basis, but rather elective, i.e. when the baby is stable and well nourished.[5]

The literature almost uniformly describes end-stage nonsalvageable testes at exploration. Some authors advocate leaving the infarcted testis in situ after exploration[1] but this does not sit well with most surgeons as gangrene and infection are potential sequelae. The exception to the "no rush" policy would be the rare case where the torsion appeared to be recent and salvage reasonably might be expected.

Most authors cite the need to repair the contralateral normal testis and point out the occasional case of bilateral neonatal torsion. However, there are no case reports where a child born with one infarcted testicle subsequently has gone on to have a similar episode on the other side, asynchronously. However, extrapolating

*Dr. Rosenberg is Chief of Urology and Dr. Zimmerman is Attending Urologist at Passaic General Hospital. Correspondence may be addressed to Dr. Rosenberg, 1198 Clifton Avenue, Clifton, NJ 07013.

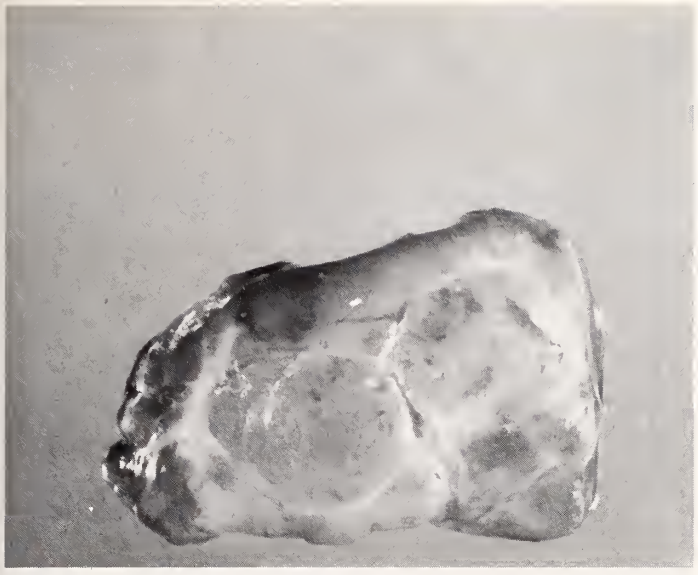


Figure 1—Gross specimen.

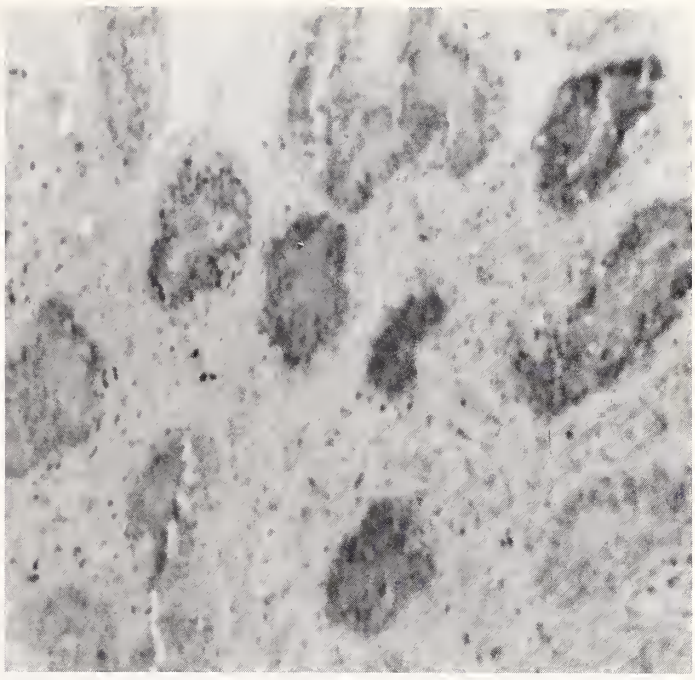


Figure 2—Microscopic section showing infarcted tubules.

from experience garnered treating teenagers, it probably is wise to repair the normal contralateral side.

REFERENCES

1. Guiney EJ, McGlinchey J: Torsion of the testes and the spermatic cord in the newborn. *Surg Gynecol Obstet* 152:273-274, 1981.
2. Valva Jr, Caldamone AA, O'Mara R, Rabinowitz R: Nuclear imaging in the pediatric acute scrotum. *Am J Dis Child* 136:831-835, 1982.
3. Falkowski WS, Firlit CF: Testicular torsion: The role of radioisotopic scanning. *J Urol* 124:886-888, 1980.
4. Kay P, Strong DW, Tank ES: Bilateral spermatic cord torsion in the neonate. *J Urol* 123:293, 1980.
5. Cumming DC, Hyndman CW, Deacon JS: Intrauterine testicular torsion: Not an emergency. *Urology* 14:603-604, 1979.

Pharmacological Basis Of Therapeutics: Anticonvulsant Agents*

Herbert M. Geller, Ph.D., Piscataway**

The actions of many anticonvulsant agents at the cellular level can be ascribed to a "modulatory" action to increase the effect of the inhibitory neurotransmitter gamma amino butyric acid. The understanding of these mechanisms may result in advances in the pharmacotherapy of seizure disorders.

In the past several years, advances in pharmacological, biochemical, and physiological techniques have brought increasing insights into the actions of anticonvulsant agents at the cellular and molecular level. In this review, some of the recent findings which indicate that many of these compounds enhance the action of endogenous inhibitory neurotransmitters in the brain will be summarized. This enhancement of inhibition by anticonvulsants then results in a general decrease of central nervous system excitability. The phenomenon of selective alteration in neurotransmission which secondarily results in alterations of brain activity has been termed "neuromodulation"; compounds which display such actions are called "modulators." Initial discussion will focus on the benzodiazepines, since the remarkable progress in our knowledge of anticonvulsant drug action was triggered by research on this class of compounds.

The first clue that benzodiazepine action might be through modulation of neurotransmission was presented in 1967 in Germany by Schmidt et al.[17] who demonstrated that, in cats, injection of diazepam (Valium®) potentiated "presynaptic" inhibition in the spinal cord without affecting other "recurrent" inhibitory pathways. Later evidence demonstrated that the inhibitory neurotransmitter, gamma amino butyric acid (GABA), plays a significant role in presynaptic inhibition in the spinal cord, whereas the recurrent (or postsynaptic) inhibition in the cord is mediated through a different amino acid, glycine. Much more evidence has accrued to suggest that benzodiazepines potentiate the actions of GABA at many loci throughout the central nervous system (CNS), and that this action is observed at concentrations which do not affect the activity of other neurotransmitters.[9]

Gamma amino butyric acid elicits its action by opening channels in the nerve membrane which are permeable to the negatively charged chloride ion, thus forcing the membrane potential more negative and decreasing the probability of activity. Additionally, open chloride channels themselves have the effect of reducing the actions of excitatory input, also decreasing activity. It would appear that in the presence of

*This article, the second in a series, is intended to be a brief review of recent advances in pharmacology and related preclinical sciences which will have utility in understanding the actions of both new and established therapeutic agents. The reviews are not designed to consider indications for specific drugs, incompatibilities, or dosage forms. Authoritative information on these topics is available in standard sources such as the *AMA Drug Evaluations*, 5th edition, 1983.

**Dr. Geller is Associate Professor, Department of Pharmacology, UMDNJ-Rutgers Medical School. Correspondence may be addressed to Dr. Geller, UMDNJ-Rutgers Medical School, P.O. Box 101, Piscataway, NJ 08854.

therapeutic concentrations of benzodiazepines, the chloride channel opens more frequently and remains open for a longer period of time, thus potentiating the actions of GABA.[20]

LIGAND BINDING SITES

The interaction between benzodiazepines and GABA was strengthened further by the discovery in 1977 of specific ligand binding sites for benzodiazepines in the brain.[12,19] These membrane sites bind clinically relevant benzodiazepines with an order of affinity that closely approximates their pharmacologic potency as therapeutic agents.[3] Moreover, the binding of these compounds is specific: neither GABA nor any other endogenous neurotransmitters displace benzodiazepines from these sites.[3] Association with GABA is reflected, however, as an ability of GABA to increase the interaction of the benzodiazepines with their binding sites, as well as the reciprocal ability of benzodiazepines to increase the binding of GABA to its receptor.[18,21] Thus, one can envision a macromolecular complex located within the nerve membrane which consists of the GABA receptor, benzodiazepine binding site, and chloride channel acting in concert to regulate the excitability of individual neurons.

The utility of this concept is expanded when one considers the actions of other agents which act to regulate the excitability of the brain as either convulsants or anticonvulsants. Bicuculline, a convulsant alkaloid of plant origin, has been demonstrated to be a competitive antagonist of GABA actions at the GABA receptor, displacing GABA from its receptor and, thereby, decreasing inhibition. Picrotoxin, another convulsant agent, exerts its actions by reducing chloride permeability; biochemical experiments have demonstrated that picrotoxin exerts these actions by attaching itself in close opposition to the chloride channel, thereby reducing chloride influx. Thus, one can expand the model we have presented to include three separate binding sites on the complex in close association with the chloride channel: the GABA receptor, the benzodiazepine binding site, and the picrotoxin binding site.

The picrotoxin binding site has generated an increasing amount of attention, not only for its ability to bind picrotoxin and structurally related compounds, but also for the ability of several other agents, both convulsants and anticonvulsants, to bind at this site. Thus far, both barbiturates with anticonvulsant actions and valproic acid (Depakene®) have been shown to compete with picrotoxin at this site.[16,22] Interestingly, the agent with the highest known affinity is a benzodiazepine compound which also is a convulsant.[16] The binding of these compounds also has been shown to be paralleled by physiological responses of the tissue. Both pentobarbital[13] and valproic acid[1] have the ability to potentiate the actions of GABA on central nervous system neurons, while the physiological actions of the convulsant compounds are quite similar to that of picrotoxin.[8] Other pharmacological interactions at this complex include the increase in binding of GABA[23] and benzodiazepines[11] in the presence of pentobarbital. Moreover, a separate binding site for phenytoin has been reported to exist[4]; this site also displays significant interactions with benzodiazepines and bicuculline.[14] Whether these interactions are pharmacologically relevant is an open question.

In parallel with the results of investigations with opiate systems, the fact that certain brain sites bind benzodiazepines with high affinity raises the question of whether there exists an endogenous compound which resembles the benzodiazepines in its actions, or whether the binding of these agents is simply adventitious. The discovery of a series of compounds which are competitive antagonists of the pharmacological actions of benzodiazepines has enabled certain studies to proceed along these lines.[10] One might suppose that, if endogenous benzodiazepine agonists were tonically active, then there would be a behavioral or physiological alteration after administration of such an antagonist. Again, there is a parallel with the results from opiate systems, where administration of naloxone produces no behavioral changes in pharmacologically naive patients: following the administration of benzodiazepine antagonist compounds, no changes are noted in behavior, nor do they produce any changes in GABA-mediated inhibition.[10] The parallel with opiate receptor mechanisms is not strict, however, as there exists yet another class of benzodiazepine ligands, derivatives of beta-carbolines, which are themselves anxiety-evoking and proconvulsant.[2] The effects of these compounds on GABA-mediated inhibition has not yet been ascertained, but one might predict that, in common with the other convulsant agents, they would reduce inhibition in the central nervous system.

An increased understanding of the biochemistry, physiology, and pharmacology of neurotransmission has provided knowledge for the pharmacotherapy of seizure disorders.

THERAPEUTIC IMPLICATIONS

The major therapeutic implications of our increased understanding of the mechanism of action of anticonvulsants are yet to come. The recent revelation that there is more than one subtype of benzodiazepine binding site, each type with a unique biochemistry[15] and anatomic localization,[24] holds out the promise of compounds which are targeted more narrowly for their effects on either seizures, anxiety, muscle relaxation, or sedation and hypnosis. The use of binding assays provides a readily available and inexpensive screen for the identification of newer compounds with increased potency, efficacy, or more favorable pharmacokinetic parameters. More recently, the anticonvulsant potency of agents which increase GABA levels by inhibiting destruction[6] or removal[7] of GABA also has been demonstrated.

The pharmacologic implication is that agents which modulate the actions of neurotransmitters are worthy of further investigation. If present-day compounds act by increasing inhibitory neurotransmission, one might speculate that agents which reduce excitatory neurotransmission within the central nervous system are candidates for anticonvulsant testing. Recent experimental evidence has supported this hypothesis as well.[5] Thus, an increased understanding of the biochemistry, physiology, and pharmacology of neurotransmission has provided fundamental knowledge for the pharmacotherapy of seizure disorders. Whether similar mechanisms underlie therapeutic advances in other CNS disorders is an open question.

REFERENCES

1. Baldino F, Jr, Geller HM: Sodium valproate enhancement of GABA inhibition: Electrophysiological evidence for anticonvulsant activity. *J Pharmacol Exp Ther* 217:445, 1981.
2. Braestrup C, Schmiechen R, Neef G, Nielsen M, Petersen EN: Interaction of convulsive ligands with benzodiazepine receptors. *Science* 216:1241, 1982.
3. Braestrup C, Squires, RF: Pharmacological characterization of benzodiazepine receptors in the brain. *Eur J Pharmacol* 48:263, 1978.
4. Burnham WM, Spero L, Okazaki MM, Madras BK: Saturable binding of ^{3}H phenytoin to rat brain membrane fraction. *Can J Physiol Pharmacol* 59:402, 1981.
5. Croucher MJ, Collins JF, Meldrum BS: Anticonvulsant activity of excitatory amino acid antagonists. *Science* 216:899, 1982.
6. Frey H-H, Popp C, Loscher W: Influence of inhibitors of high affinity GABA uptake on seizure thresholds in mice. *Neuropharmacology* 18:581, 1981.
7. Gale K, Iadarola MJ: Seizure protection and increased nerve-terminal GABA: Delayed effects of GABA transaminase inhibition. *Science* 208:288, 1980.
8. Geller HM: Water soluble benzodiazepines with agonistic and antagonistic actions on GABA-induced inhibition in cultured hypothalamus. *Neurosci Lett* 15:313, 1979.
9. Geller HM, Hoffer BJ, Taylor DA: Electrophysiological actions of benzodiazepines. *Fed Proc* 39:3016, 1980.
10. Haefely W, Bonetti EP, Burkard WP, Cumin R, Laurent JP, Mohler H, Pieri L, Polc P, Richards JG, Schaffner R, Scherschlicht R: Benzodiazepine antagonists, in Costa E (ed), *Benzodiazepines—From Molecular Pharmacology to Clinical Practice*. New York , NY, Raven Press, 1983.
11. Leeb-Lundberg F, Snowman A, Olsen RW: Barbiturate receptor sites are coupled to benzodiazepine receptors. *Proc Natl Acad Sci USA* 77:7468, 1980.
12. Mohler H, Okada T: Properties of ^{3}H-diazepam binding to benzodiazepine receptors in rat cerebral cortex. *Life Sciences* 20:2101, 1977.
13. Nicoll RA, Eccles JC, Oshima T, Rubia F: Prolongation of hippocampal inhibitory postsynaptic potentials by barbiturates. *Nature* 258:625-627, 1975.
14. Okazaki MM, Madras BK, Livingston EK, Spero L, Burham WM: Enhancement of ^{3}H-phenytoin binding by diazepam and (+) bicuculline. *Life Science* 33:409, 1983.
15. Niehoff DL, Mashal RD, Horst WD, O'Brien RA, Palacios JM, Kuhar MJ: Binding of a radiolabeled triazolopyridazine to a subtype of benzodiazepine receptor in the rat cerebellum. *J Pharm Exp Ther* 221:607, 1982.
16. Olsen RW, Leeb-Lundberg F, Napias C: Picrotoxin and convulsant binding sites in mammalian brain. *Brain Res Bull* 2:217, 1980.
17. Schmidt RF, Vogel ME, Zimmermann M: Die wirkung von diazepam auf die prasynaptiche hemmund und andere ruckenmarksreflexe. *Naunyn-Schmiedeberg's Arch Pharmacol* 258:69, 1967.
18. Skerritt JH, Willow M, Johnston GAR: Diazepam enhancement of low affinity GABA binding to rat brain membranes. *Neurosci Lett* 29:63, 1982.
19. Squires RF, Braestrup C: Benzodiazepine receptors in rat brain. *Nature* 266:732, 1977.
20. Study RE, Barker JL: Diazepam and (-)-pentobarbital: Fluctuation analysis reveals different mechanisms for potentiation of -aminobutyric acid responses in cultured central neurons. *Proc Natl Acad Sci USA* 78:7180, 1981.
21. Tallman JF, Thomas JW, Gallagher DW: GABAergic modulation of benzodiazepine binding site sensitivity. *Nature* 274:383, 1978.
22. Ticku MK, Davis WC: Effect of valproic acid on ^{3}H dihydropicrotoxinin binding sites at the benzodiazepine-GABA receptor-ionophore complex. *Brain Res* 223:218-222, 1981.
23. Willow M, Johnston GAR: Enhancement by anesthetic and convulsant barbiturates of GABA binding to rat brain synaptosomal membranes. *J Neurosci* 1:364, 1981.
24. Young WS III, Niehoff D, Kuhar MJ, Beer B Lippa AS: Multiple benzodiazepine receptor localization by light microscopic radiohistochemistry. *J Pharmacol Exp Ther* 216:425, 1981.

PEDIATRIC BRIEFS

RICHARD H. RAPKIN, M.D., FRANKLIN C. BEHRLE, M.D., SHYAN C. SUN, M.D., NEWARK*

Pediatric Briefs *are abstracted from the* Newsletter, *a continuing medical education project of the Department of Pediatrics, UMDNJ-New Jersey Medical School and the Children's Hospital of New Jersey.*

Taylor EM, et al.: Family and community factors associated with infant deaths that might be preventable. *Br Med J* 787:871, 1983.

"For a child to be treated successfully the parents first must recognize that he is ill and then must recognize the need to take action. Next, they must be able adequately to communicate their anxieties to an appropriate member of the health care service, and these services must be able to recognize and respond to the families' needs." A detailed study was made of all deaths between age 8 days and 2 years in Sheffield, England, in a two-year period. All patients were matched to living controls. Specific analysis was made of families of children who died of treatable diseases. These families had significantly greater numbers of adverse social factors (domestic and financial problems, mother and father's upbringing, housing, mother and father's intelligence and state of health, and family crises). The authors conclude that adverse social factors play a substantial role in failure of identification of the presence of illness and inadequate responses. These factors "are complex and not immediately susceptible to purely economic intervention or necessarily to an unselective increase in primary health care. Perhaps we should be more conscious of the differing needs of individual families." The adverse factors noted were related to the economic state but appeared not to be related to social class.

Tager IB, et al.: Longitudinal study of the effects of maternal smoking on pulmonary function in children. *N Engl J Med* 309:699, 1983.

A careful study demonstrated that exposure to maternal smoking (passive) has substantial effects on pulmonary function in children. This effect is seen in children by the time they are aged 5 to 9 years. Paternal smoking had little or no significance. Aside from the obvious effect of "setting a bad example" leading to subsequent smoking by the child himself, passive smoking itself may have an important effect on the development of COPD in adulthood.

Bensahel H, et al.: Bone scintigraphy in Perthes' disease. *J Pediat Orth* 3:302, 1983.

Eighty-six percent of 71 hips with Perthes' disease were abnormal on bone scanning and were very specific for same. The scan was positive 4 to 6 weeks before x-rays became abnormal and usually showed decreased or absent uptake in the head of the femur. The scan never was falsely positive and was very sensitive. The scan became normal far earlier than the radio-

*Abstracts are from the Department of Pediatrics *Newsletter*, UMDNJ-New Jersey Medical School, Vol. 8, No. 12, 1983. Dr. Rapkin is Editor and Medical Director of Children's Hospital of New Jersey, Newark. Coeditors are Dr. Behrle, Professor and Chairman, Department of Pediatrics, UMDNJ-New Jersey Medical School, and Dr. Sun, Director of Neonatology, Children's Hospital of New Jersey, Newark. Correspondence may be addressed to Dr. Rapkin, Children's Hospital of New Jersey, 15 South 9th Street, Newark, NJ 07107.

graph and therefore was helpful in prognosis and treatment.

Comment: As the authors note, bone scanning is very helpful in the differential diagnosis of hip pain, in addition to being specifically helpful in Perthes' disease.

Gross RH, et al.: Early management and decision making for the treatment of myelomeningocele. *Pediatrics* 72:450, 1983.

A mere generation ago, most children born with myelomeningocele died in infancy. Now, vigorous treatment yields high rates of survival—and high rates of continued morbidity. Here, as in other areas of rapid therapeutic advance, what was once a matter of fate is now a matter of choice. Should this particular child be vigorously treated or allowed to die?

The authors carefully review some of the relevant clinical and ethical literature. Against this background they report the experience of their center (University of Oklahoma) with a process for selecting which infants should receive vigorous treatment. Over a five-year period, 69 babies were evaluated, 36 of whom were recommended for vigorous treatment. Of the 33 babies for whom only supportive care was recommended, 5 were initially treated at the parents' insistence, 2 underwent delayed vigorous treatment, 1 was treated subsequently on a "crisis management" basis (after survival due in part to meticulous care at home), and 1 was lost to follow up. The remaining 24 children died between 1 and 189 days (mean 37 days) receiving only supportive care.

The principal features of the decision process which led to these outcomes are as follows: 1) parents made the decisions following extensive informing and emotional support by the team; 2) in no case in which the parents refused treatment did the professionals feel there was a strong case for treatment; 3) there was a broadly multidisciplinary team; 4) there was consistent primary care by one team member throughout; 5) there was a firm belief that urgent surgical closure usually is not required, thus delaying team evaluation until after acute treatment; and 6) surgeons who are not expected to maintain followup throughout growth were excluded from urgent decisions regarding treatment plans.

The authors asked themselves two questions about their program: 1) Is it workable? and 2) Does it address, in a reasonable fashion, the present ethical (and legal) dilemma surrounding this issue? Both questions were answered with a confident, though appropriately qualified, yes.

Comment: This is a superb article: clear, thoughtful, and important. Both the program itself and the article reporting it reflect a balance between boldness and care, between self-reliance and social responsiveness that is so necessary to leadership in these matters. Such qualities are not peculiar to Oklahoma. One or more New Jersey hospitals could add to the experience needed for a technologically dazzling and thus morally uncertain medical future.

The ethical values which seem to be emphasized in the Oklahoma City approach are the right to privacy (autonomy) and the avoidance of harm. The team not only meticulously supports and informs the parents, but shields them from pressures which might be expected to emphasize indications for urgent intervention before deliberation. Wishes to "maintain hope" or "avoid guilt" are not allowed to obscure the parents' right to know the negative results of surgical experience as well as what surgical interventions often have accomplished. Meanwhile, the whole approach is based explicitly on an appreciation that there are circumstances in which life is not preferable to death and that preservation of life at the cost of enormous suffering may sometimes be neither responsible nor loving nor socially mandated.

In contrast, the Reagan Administration's Baby Doe regulation emphasized the ethical principle of equity, i.e. equal treatment for all classes of persons. The chief evidence of the equity principle at work in the Oklahoma experience is the apparent consistency of the team's operation, affording to all parents of infants born with myelomeningocele equal access to an apparently superb set of decision-making resources. (D. Price, Ph.D., Adj. Asst. Professor, Health Care Humanities)

Yogman MW, et al.: Diet and sleep patterns in newborn infants. *N Engl J Med* 309:1147, 1983.

Serotonergic transmission in neurons is associated with sleep. Synthesis of serotonin is dependent upon the availability of the amino acid tryptophan. Brain tryptophan is dependent upon diet. Adults given pharmacologic doses of tryptophan fall asleep more quickly than with placebo. Newborns were studied comparing a tryptophan feeding versus placebo (valine). Infants fed tryptophan fell asleep more quickly and entered quiet sleep sooner. The differences were very significant.

Comment: Nature's hypnotic! Soon we will need a correlation with day and night variation in production of tryptophan by the lactating mother. I'm not skeptical, just amazed that behavior and molecules are revealing themselves to be so easily related. We will need just an increase in x to become euphoric; an increase in y to be more relaxed; for better SAT scores. What next is in store for us?

Mulvihill S, et al.: Incidental appendectomy in infants and children. *Arch Surg* 118:714, 1983.

Incidental appendectomy in infants and children during clean abdominal procedures has been done electively for many years in pediatric surgery. This paper summarizes and confirms this conclusion, i.e. that elective incidental appendectomy in the child being operated upon for another abdominal condition is well worth the few extra minutes spent.

Comment: In Children's Hospital of New Jersey, we have used this approach for at least 20 years. There have been no related complications. In all cases, there has been the procedure of inverting the stump or inverting the appendix. Opportunities to inspect the appendectomy site during a second surgical procedure at a later date always revealed a clean smooth site of the old appendectomy. This issue has been emphasized by two recent cases in which a left-sided acute appendicitis was diagnosed fortunately, and was managed appropriately in patients with malrotation who did not have incidental appendectomy when initially operated on.

DOCTORS' NOTEBOOK

Trustees' Minutes; President's Column; UMDNJ Notes; MSNJ Auxiliary; AMNJ Report; New Members; Maimonides Award Recipient; Physicians Seeking Location in New Jersey

Trustees' Minutes: February 19, 1984

A regular meeting of the Board of Trustees was held on February 19, 1984, at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

Report of the President . . .
No-Fault Insurance . . . Reaffirmed opposition to any physician fee schedule in regard to automobile insurance.

Report of Executive Director . . .
(1) MSNJ 1984 Paid Membership . . . Noted that paid memberships at the end of January totalled 4,400.
(2) Physician Reimbursement by DRG . . . Noted that there is no indication of any proposal to include physicians under a DRG format at Shore Memorial Hospital.
(3) Annual Meeting . . . Voted to proceed with the Annual Meeting as scheduled at Resorts International Casino-Hotel.
(4) MSNJ Financial Statements . . . Approved the financial statements for the period ending January 31, 1984.
(5) Litigation Report . . .
(a) State Board of Medical Examiners *v* Aluri; *v* Strauch . . . Noted that the New Jersey Supreme Court denied certification in the Aluri and Strauch litigation; the issue of a prejudiced forum and a merger of functions must be corrected by legislation.
(b) State Board of Medical Examiners *v* Greco . . . Noted that oral argument on the Greco case still is pending in the Appellate Divison.

UMDNJ . . .
Physician Reimbursement by DRG . . . Noted that Dr. Bergen mentioned that nothing actively was being developed at this time on either models or testing of DRGs to include physicians in Medicare payments.

NJ Hospital Association . . .
Definition of a Health Care Facility . . . Agreed to accept the concept of a dinner-meeting format with the Board of Trustees of MSNJ and NJHA to discuss the proposed legislative definition of a health care facility.

Executive Subcommittee, Committee on Impaired Physicians . . .
(1) Restructure of the Committee . . . Approved the restructuring of the Committee on Impaired Physicians to include: Executive Subcommittee and General Committee Membership (previously referred to as panel of intervenors/monitors), with Executive Subcommittee members meeting four times a year and the General Committee members to meet at least twice a year.
(2) Employment of a Certified Alcoholism Counselor . . . Approved the following recommendation:

That the Board of Trustees approve the position and employment of a certified alcoholism counselor for the Impaired Physicians Program.

Special Committee on Long-Range Planning and Development . . .
Direct Candidacy for Elective Office . . . Approved the following recommendation:

That the Nominating Committee develop a slate of two candidates for the position of Judicial Councilor.

Disapproved the following three recommendations:

That the Nominating Committee develop a slate of two candidates for the position of Treasurer.

That the Nominating Committee develop a slate of two candidates for the position of Secretary.

That the Nominating Committee develop a slate of candidates for the position of Second Vice-President.

Disapproved unanimously the following two recommendations:

That the Nominating Committee develop a slate of two candidates for the position of First Vice-President.

That the Nominating Committee develop a slate of two candidates for the position of President-Elect.

Was not in favor of the following recommendation:

That the Nominating Committee develop a slate of two candidates for each Trustee position.

Committee on Medical Aspects of Sports . . . Approved the following recommendation:

That the Commissioner of Education and the Division of Special Needs Handicapped Education be urged to adopt guidelines for the school system that all Down's syndrome children be required to have x-rays of the cervical spine, to evaluate the presence or absence of the atlantoaxial condition prior to being permitted to participate in any activity resulting in hyperextension, radical flexion, or direct pressure on the neck or upper spine.

Specialty Society Representation in MSNJ House of Delegates . . . Approved the seating of the following specialty societies in the House of Delegates: New Jersey Chapter, American College of Surgeons; New Jersey Orthopaedic Society; New Jersey Society of Internal Medicine; New Jersey Academy of Ophthalmology and Otolaryngology; and Radiology Society of New Jersey. Did not approve the admission of the American College of Physicians of New Jersey. Approved the seating of the following specialty societies in the House of Delegates: New Jersey Dermatological Society; New Jersey Gastroenterological Society; New Jersey Neurosurgical Society; Neurological Association of New Jersey; Urologic Society of New Jersey; New Jersey Society of Plastic and Reconstructive Surgeons; New Jersey Society of Thoracic Surgeons; and Oncology Society of New Jersey.

Old Business . . .

1985 Annual Meeting . . . Referred to the Committee on Annual Meeting communications from Middlesex County Medical Society, Morris County Medical Society, and Passaic County Medical Society concerning the 1985 Annual Meeting, and a request that the Committee develop a questionnaire for distribution at the upcoming meeting on the issue of where the 1985 Annual Meeting should be held.

(2) Medicaid Personal Physician Plan . . . Approved the recommendation that MSNJ does not endorse the Medicaid Personal Physician Plan being tested in Morris, Sussex, and Warren Counties. Directed that the State Commissioner of Human Services be advised of MSNJ's position.

(3) Peer Review Organizations . . . Referred to the Ad Hoc Committee on Study of PRO, a communication from Passaic County Medical Society expressing opposition to MSNJ becoming the prime contractor for statewide peer review organizations.

New Business:

(1) Membership of the Committee on Peer Review (DRG Appeals) . . . Directed all county medical societies be notified that if they wish representation on the Committee on Peer Review (DRG Appeals) they should name an individual to serve in that capacity, to be appointed by MSNJ's president.

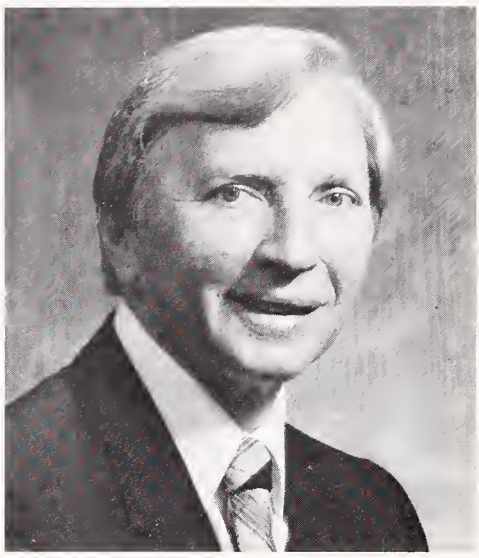
(2) Proposed Resolution for 1984 Annual Meeting . . . Approved for submission by the Board to the 1984 House of Delegates a resolution that MSNJ urges individual physicians to pay the dues of their medical assistants to the American Association of Medical Assistants-State of New Jersey, Inc.

(3) State Board of Medical Examiners Proposed Rule . . . Approved proposed rule N.J.A.C. 13:35-2.13—Limited Privileges and Conditions of Practice Permitted for a Graduate Physician Pending Licensure; the rule would allow limited privileges for graduate physicians pending licensure.

President's Column

Alexander D. Kovacs, M.D.

How many are aware that the United States is more socialistic than other western countries who formally have adopted socialistic systems? The great lie of socialism and its bedrock foundation is the promise to provide for all citizens equally. We all know that all men are not inherently equal. Our Constitution promises only the right to pursue happiness. Socialism attempts to make all people equal through redistribution of wealth.



Alexander D. Kovacs, M.D.

France and England are examples of structural socialism wherein land and the machinery of production are property of the government and not of the individual. In the United States, we have functional socialism which is more subtle and dangerous to our liberty. Equality is expected to be achieved by taxing the earners of wealth to provide benefits for the less advantaged. The essence of the system is to promote social justice by imposing and collecting huge taxes.

Functional socialism almost is impossible to dismantle. There are too many bureaucrats, welfare groups, and politicians with vested interest in continuing the redistribution of wealth. We are approaching a total welfare state but few will call it a socialistic state.

The private enterprise system is based on a realistic appraisal of human nature. Socialism in its pure form is based on an idealistic conception of that nature. In this country, collectivist authorities use legislative pressure to oblige us to conform to the ideal.

The private enterprise system is one of individual freedom. No one has to be forced to act in his own self-interest; it comes naturally. The system is more productive since each person's efforts will have a great measurable effect on his own situation. In the collective society, the citizen is motivated by fear rather than by any hope of personal gain. Proponents of such systems promise castles in the air and deliver earthly prisons. Yet, they remain obstinate in their error, despite decades of experience which prove the inefficacy of the system.

What has this to do with medicine? Note the changes occurring in our profession. We are slowly but surely being converted into a socialized medical system via cost effectiveness, competitive regulations, judges and juries, politicians, insurance companies, businesses, and unions. Everyone preaches quality medical care, no one wants to pay for it.

In the United States, regulations governing the practice of medicine and the provision of health care have become burdensome, inflexible, and restrictive. Misunderstanding, misinformation, and mistrust abound and there is a reluctance on the part of too many in medicine to actively and individually counter this destructive situation. We are so busy protecting and promoting our own specialties that we have lost sight of the overall picture. We generally have been unwilling to be involved in any significant effort to help sell the very system which allows us to sell our services to the profit of our patients and ourselves.

We must stop treating public relations as a side issue. We must meet the challenge of enlisting public support. We must write and speak to the public in such a way that the person on the street can understand what we say. We must provide medical care at reasonable cost and demonstrate that the government cannot do the job for less. The public must be taught the folly of tinkering with the system by calling for more government intervention.

Why the hostility toward physicians that focuses on the ability to make a good living? Why does the media constantly convey that we are taking bread from the mouths of the poor? Commentators and public figures like Senator Kennedy portray us in the national media as money-hungry professionals with no regard for the health of our patients. Who mentions the lives we save or the

money we save the public by keeping them well and productive?

Can we alter what seems to be the inexorable cycle of events? We know what has happened in England and elsewhere. We know it, yet we continue to march toward it. Once in America, we did take charge of our destiny and, in less than 200 years, we created a standard of living which had never been dreamed of as possible. We must be willing and proud to fight for freedom again. There can be no personal freedom, no religious freedom, and no political freedom without economic freedom! We must win the battle of ideas!

To those who say there is nothing we can do, I offer the words of Plato: "The punishment of wise people who refuse to be involved in the affairs of government is to be governed by unwise people."

UMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

Obtaining objective data for the diagnosis and treatment of mental disorders long has been an elusive goal for the field of psychiatry. Now, Leonide Goldstein, D.Sc., professor of psychiatry at UMDNJ-Rutgers Medical School, feels specialists at the Community Mental Health Center, Piscataway, are a step closer to developing an objective method.

By using an electroencephalogram (EEG), a patient's brain waves are amplified, recorded on paper, and fed into a computer for analysis. In most cases, the procedure enables researchers to recognize if a person is suffering from mental illness and, if so, what kind. The EEG also charts what changes—if any—have occurred as a result of treatment.

Electrodes are attached to six areas of the scalp and patients then are asked to perform one of a number of thinking functions, such as concentrating on words or images.

Active thinking processes result in differently directed changes between the activities of the two cerebral hemispheres. In paranoid schizophrenics, for example, there is a clear-cut abnormality in the left hemispheric function. They perform visual functions well, but not verbal ones. In patients who are depressed, the opposite is true. The right hemispheric function is abnormal, and they perform verbal tasks better than those of a visual nature.

Once the mental illness and its severity are diagnosed, the EEG then is used to test the efficacy of treatment. When successful, a re-establishment of normal brain patterns during drug treatment usually is seen.

A new laboratory at UMDNJ-Rutgers School, Piscataway, is providing physicians and hospitals with analysis and diagnosis of conditions ranging from acquired immunodeficiency syndrome (AIDS) and hepatitis to infertility and cancer.

Under the direction of Karel F. Raska, Jr., M.D., Ph.D., professor of pathology and microbiology, the diagnostic laboratory features the state's only operational Cytofluorograf available for direct patient care. Manufactured by Johnson & Johnson, the instrument provides rapid analysis reported back within 24 hours, and the laboratory provides courier service throughout the state.

By marking blood specimens with monoclonal antibodies tagged with a dye sensitive to the machine's two lasers, researchers are able to determine the amount of specific lymphocyte types or other cell types present in a patient's white blood cells.

The clinical immunology division of the laboratory currently serves Middlesex General-University Hospital and St. Peter's Medical Center, New Brunswick, as well as Somerset Medical Center, Muhlenberg Hospital, and the VA Hospital, Lyons.

A comprehensive sickle cell anemia program has been initiated at the Newark campus of UMDNJ. Under the direction of Prakash Kaur, M.D., assistant professor of pediatrics at UMDNJ-New Jersey Medical School, the endeavor will combine treatment, education, genetic counseling, psychosocial support, screening, and clinical and biomedical research in its battle against this inherited blood disorder.

The disease occurs in one of every 500 to 600 births among black people.

The program provides clinical care for children and adolescents under 20 at four participating Newark hospitals: UMDNJ's University Hospital, Children's Hospital of United Hospitals Medical Center, Newark Beth Israel Medical Center, and Saint Michael's Medical Center. Education and community outreach components are being coordinated by the Sickle Cell Foundation of New Jersey.

Currently, the key catchment area for medical care is Newark and the surrounding communities. Education, screening, and counseling efforts will blanket Essex, Hudson, Middlesex, and Union counties, and patient referrals will be accepted from anywhere in the state. The primary inpatient units are at University Hospital's hematology service and at Children's Hospital, both of which provide around-the-clock care to patients.

Children with the disease receive outpatient care for routine checkups and parental consultation every 6 to 12 weeks. An afternoon clinic has been started so that children can be seen after school.

The sickle cell program also has an educational component for professionals, consisting of conferences and lectures on cases and updates. Participants are physicians, hospital staff, and medical students.

MSNJ Auxiliary

Gale Wayman
President

Several months ago, while reading *The Healing Heart* by Norman Cousins, it became more and more apparent that this book would be excellent reading for the medical community.

Although written for the layman, this book addresses many of the problems that face the physician today. The author is in the unique position of being a member of the faculty of a medical school, UCLA Medical School, and a patient who suffered a heart attack at the same institution. Cousins's special field of study has been the biochemistry of emotion, and he especially is interested in the way attitudes and emotions can bring on disease or improve the prospects of recovery.

The author has articulated many problems that face the physician and gives a new way of meeting these problems. Today, the physician deals with better educated and more sophisticated patients

who want to participate in decision-making concerns about their own health care.

"Health" now is news! Every night on television, the public hears about the latest medical discoveries; entire magazines are devoted to health; and entire stores cater to health care needs. While patients are participating more in their own care, they also are suing more, and there has been an eruption of malpractice suits. At the same time, physicians are expected to use new technology; they also are expected to keep health care costs down. These are but a few of the problems that are addressed in *The Healing Heart.* It may not have all the answers, but it is a great start!

The Auxiliary will have this book available for $10 to sell as a fund-raiser during the convention in Atlantic City. Please look for it!

AMNJ Report

Paul J. Hirsch, M.D.
President

The Board of Trustees of the Academy of Medicine of New Jersey has named the 1984 recipients of the awards which will be presented at our Annual Dinner on Wednesday, May 23, 1984, to be held at the Chanticler in Short Hills.

Alfred A. Alessi, M.D., will receive the Edward J. Ill Award "presented annually to that physician of New Jersey who merits recognition by the Academy for distinguished service as a leader in the medical profession and in the community at large." Recent recipients have included Doctors Leon Smith, Arthur Krosnick, James Todd, and Arthur Bernstein. Dr. Alessi is a past president of the Medical Society of New Jersey, and is an AMA delegate. He also is chairman of the Education Committee of the Academy of Medicine. He serves on many boards and committees, and is a frequent speaker on topics of interest to the medical community.

The Academy's Citizen's Award is "presented annually to that citizen or group of citizens of New Jersey who merit recognition by the Academy for distinguished service in the interest of the health and welfare of the community at large." The 1984 Citizen's Award has been granted to Congressman James Courter. Mr. Courter has demonstrated an overwhelming commitment to the health needs of the citizens of New Jersey. He particularly has been active in efforts to increase public awareness and funding for organ transplants. He also has been very much concerned about the health needs of the elderly and has been able to play an active role in this problem through his position on the House Aging Committee. He has talked before Congress to focus attention on the tragedy of Alzheimer's disease. He also has been active in efforts to deal with drunken driving and drug abuse. He has worked to protect health benefits for veterans, and has sponsored legislation expanding coverage for victims of Agent Orange.

The Academy of Medicine's Annual Dinner, at which these awards will be granted, is a major event in the Academy's calendar. Last year, this dinner was oversubscribed; many requests for reservations had to be declined. We expect a similar large number this year to honor these outstanding recipients.

Mr. Charles Heitzmann, Executive Director of the Academy of Medicine, and I attended the 9th Annual Meeting of the Alliance for Continuing Medical Education. This meeting focused on the need for organizations to help physicians individualize their educational programs, so as to be most pertinent to their own practices. Our approach to CME has been changing rapidly, because of the same pressures that affect other aspects of medicine, and because of advancing technology. The standard approaches of meetings, conferences, and seminars (usually large, long, and far away) do not seem to meet the needs of physicians today. Cost factors increasingly are more important. Funding for hospital CME programs is expected to diminish under the federal DRG system. These same factors may decrease funds available to full-time physicians to attend educational programs which require travel. There is a trend today for education to be closer to home, to be more directly related to the individual's practice, and to use modern technology. Furthermore, since only about 6 percent of medical mistakes relate to a lack of knowledge, there is agreement that CME must relate not only to knowledge, but to changing behavior. "Individualized CME" may include counseling services provided by organizations to help the individual determine those programs and processes which are most suitable to a specific educational need. The concept of tailoring CME to the individual physician is not a new one, but it is gaining in popularity and we are likely to hear more of it in the future.

The speaker at the February First Wednesday program was James Todd, M.D. On March 7, 1984, the First Wednesday speaker was Charles Whelan, M.D. His topic was, "Does Governmental Control in the Purchase of NMRs Have an Impact on the Future of the Private Office Practice of Medicine?"

New Members

The Journal would like to welcome the following members to the Medical Society of New Jersey:

Bergen County
Hormoz Ashtyani-Asl, M.D., Fair Lawn
JoAnne Betta, M.D., Tenafly
Dennis P. Daut, M.D., Ridgewood
Sybil E. N. Duchin, M.D., Ridgewood
Mitchell S. Engler, M.D., Teaneck
Ira Esformes, M.D., Westwood
Edward Fass, M.D., Fort Lee
Martin A. Fechner, M.D., Teaneck
Howard L. Frey, M.D., Midland Park
David V. Habif Jr., M.D., Teaneck
Harry D. Harper, M.D., Englewood
Jerald B. Hershman, M.D., Allendale
Andrew R. Herzog, M.D., Wyckoff
George B. Leber, M.D., Englewood
John M. Lloyd, M.D., Westwood
Jacqueline S. Lustgarten, M.D., River Edge
Suri B. Ponamgi, M.D., Fort Lee
Glenn R. Silbert, M.D., Hackensack
Robert E. Waidmann, M.D., Fort Lee
Stanley E. Waintraub, M.D., Englewood
Steven J. Weisholtz, M.D., Leonia

Burlington County
Richard M. Goldstein, M.D., Medford Lakes
Vicky L.A. Mitruka, M.D., Willingboro
Kenneth D. Schulner, M.D., Willingboro

Camden County
Ivan F. Ackerman, M.D., Camden
Clifford J. Ameduri, M.D., Camden
Frederick L. Ballet, M.D., Haddonfield

Jessica P. Byrne, M.D., Camden
Carolyn S. Crawford, M.D., Camden
Elizabeth Fond-DeLeon, M.D., Camden
M. Arif Hashmi, M.D., Cherry Hill
Emily S. Miller, M.D., Haddon Heights
Franklin I. Rosenberg, M.D., Voorhees

Cape May County
Donald F. Lyle, M.D., Ocean City

Cumberland County
Kathleen W. McNicholas, M.D., Browns Mills
Steven L. Rodis, M.D., Bridgeton
Vincent J. Taormina, M.D., Cherry Hill

Essex County
Neil H. Adelman, M.D., Millburn
Kenneth S. Bannerman, M.D., Glen Ridge
Kenneth Cubelli, M.D., Fairfield
Gary C. DeGrande, M.D., Glen Ridge
Luis M. Guerra, M.D., Belleville
Thomasina Ivey, M.D., Newark
Frank L. Kane, M.D., Verona
Dominick J. Ligresti, M.D., Belleville
Howard Louis, M.D., Upper Montclair
Madhavi N. Maniar, M.D., East Orange
Bernard J. Manney, M.D., Caldwell
Daniel D. Manzi, M.D., South Orange
Henry J. McCabe, M.D., Maplewood
William Oppenheim, M.D., Roseland
Thomas R. Ortiz, M.D., Verona
Frank T. Padberg Jr., M.D., Newark
Paul Paroski Jr., M.D., Newark
Barry R. Seidman, M.D., Millburn
Michael P. Wujciak, M.D., Bloomfield

Gloucester County
Robert J. Cales, M.D., Mantua
Karl H. Ebert, M.D., Cherry Hill
Lawrence K. Epple Jr., Woodbury Heights

Hudson County
Subbian Dharmalingam, M.D., Mountainside
Pierre Guibor, M.D., New York, NY
Young W. Kim, M.D., North Bergen
Joseph Zicarelli, M.D., Staten Island, NY

Hunterdon County
Gerald E. Batt, M.D., Flemington
Robert G. Coates, M.D., Hampton
Jeremy C. Hewens, M.D., Milford
Brian M. Quinn, M.D., Flemington

Mercer County
Byung-Kee Bang, M.D., Trenton
Robert S. Collins, M.D., Trenton
Jay R. Goldstein, M.D., Trenton

Middlesex County
Gloria A. Bachmann, M.D., Edison
Young K. Cho, M.D., Staten Island, NY
Leo A. Fabbro, M.D., Metuchen
Kerry M. Fagelman, M.D., New Brunswick
Stephen J. Gordon, M.D., New Brunswick
Malvin S. Keller, M.D., Edison
Sanford L. Klein, M.D., New Brunswick
Ashok Kumar, M.D., Highland Park
Wen Jung Lin, M.D., Milltown
Harold V. McKenna, M.D., South Amboy
Erwin Mermelstein, M.D., Highland Park
Arthur Miller, M.D., East Brunswick
Anthony J. Passannante Jr., M.D., Metuchen
Allan B. Plumser, M.D., Somerset
Andrew B. Sachere, M.D., Somerset
Peter M. Scholz, M.D., New Brunswick
Gregory E. Scott, M.D., New Brunswick
Praful M. Shah, M.D., Piscataway
Edward J. Walkowski Jr., M.D., Old Bridge

Monmouth County
Hugo Jose M. Cerri, M.D., Freehold
Stephen T. Dudick, M.D., Red Bank
Robert G. Josephberg, M.D., Freehold
Wai Hung Edmund Kwong, M.D., Red Bank
Kenneth P. Lipkowitz, M.D., Howell
William K. Power Jr., M.D., Ocean Grove
Tsui H. Rangam, M.D., Irvington
Sanford H. Vernick, M.D., Red Bank

Morris County
Mark E. Maletsky, M.D., Rockaway
Pradip Sahdev, M.D., Morristown

Ocean County
Mathew K. Kandathil, M.D., Lakewood
Yeshavanath P. Nayak, M.D., Toms River
Joseph P. Padula, M.D., Pt. Pleasant

Passaic County
Joseph B. Baratta, M.D., Clifton
Peter M. Crain, M.D., Paterson
Amir Ghandchi, M.D., Wayne
James M. Hyde, M.D., Paterson
Ernest D. Kirrer, M.D., Clifton
Somchai Kulwatdanaporn, M.D., Paterson
Jeffrey I. Marder, M.D., Paterson
Warren L. Maresca, M.D., Paterson
Evangelos Megariotis, M.D., Clifton
Robert A. Schultz, M.D., Paterson
David Scolnick, M.D., Paterson
Joseph A. Tarta, M.D., Wayne

Salem County
Domenic F. Coletta, M.D., Salem
Devendra M. Jani, M.D., Salem

Union County
Paul J. Carniol, M.D., Summit
Michel-Ange Ferdinand, M.D., Elizabeth
Eve Anne Feret, M.D., Newark
Mark S. Gold, M.D., Summit
Ilia Segal, M.D., Hillside
Michael B. Wax, M.D., Summit

Warren County
William P. Braun III, M.D., Phillipsburg
Ila A. Shal, M.D., Phillipsburg

Dennis R. Filippone: The Maimonides Award Recipient

Congratulations are in order for Dennis R. Filippone, M.D. The State of Israel Bonds-Medical Arts Division has selected him for its prestigious Maimonides Award. The citation reads: "For notable leadership and outstanding participation in the Health Professions and Service Division of Israel Bonds and for devoted support of the vital program to develop the economy of the state of Israel as a means of realizing its hopes for a future of peace and progress."

Dr. Filippone, the surgical director of the Renal Transplant Service at Saint Barnabas Medical Center, Livingston, is a member of our Essex County component and of the American Medical Association. He will be the next president-elect of the Academy of Medicine of New Jersey.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ALCOHOLISM—George W. Miller Jr., M.D., 77 Grove St., Apt. 8, Montclair, NJ 07042. UMDNJ 1980. Available July 1984.

ANESTHESIOLOGY—Jan Charles Horrow, M.D., 131 Pond Brook Rd., Chestnut Hill, MA 02167. Pennsylvania 1977. Board certified. Group, academia, HMO. Available.

CARDIOLOGY—Aubrey Orrin Lewis, M.D., 200 Carman Ave., Apt. 21-F, East Meadow, NY 11554. SUNY-Syracuse 1979. Also, general internal medicine. Board certified (IM). Solo, partnership, group, academia (cardiology). Available July 1984.

FAMILY MEDICINE—Jaime F. Lara, M.D., 6045 Palisade Ave., West New York, NJ 07093. Seville (Spain) 1979. Board eligible. Partnership or institutionally based. Available.

GASTROENTEROLOGY—Albert M. Harary, M.D., 2121 N. Bayshore Dr., Apt. 1001, Miami, FL 33137. Columbia 1978. Also, general internal medicine. Board certified (IM). Group, partnership, solo. Available July 1984.

Prakash V. Huded, M.D., 80-15 41 Ave., # 606, Elmhurst, NY 11373. Karnatak (India) 1970. Board certified. Solo, group, partnership. Available.

H.L. Kirschenbaum, M.D., 780 Woolley Ave., Staten Island, NY 10314. New York Medical College 1977. Board eligible. Also, internal medicine. Partnership, group, full-time hospital. Available July 1984.

Mark F. Tsai, M.D., 1715 Stanford Dr., Columbia, MO 65201. National Taiwan University 1977. Also, internal medicine. Board certified. Available July 1984.

INTERNAL MEDICINE—Nicholas Bertini, M.D., 663 Hudson Ave., Albany, NY 12203. SUNY-Buffalo 1980. Board eligible. Group, partnership, solo. Available June 1984.

Harold J. Brown, M.D., 260 Eggerts Rd., Lawrenceville, NJ 08648. UMDNJ 1982. Primary care clinic, HMO, group, partnership. Available July 1985.

Palamadai S. Duraiswami, M.D., 64-A Oneida Ave., Centereach, NY 11720. Stanley Medical College (India) 1976. Board eligible. Available.

Z.U.A. Farooqui, M.D., Plaza Professional Bldg., Bayshore Rd. and Greenwood Ave., Box 238, Villas, NJ 08251. Aurangabad Medical College (India) 1972. Board eligible. Group or partnership. Available.

Elliott Friedman, M.D., 25 Penny La., Baltimore, MD 21209. SUNY-Syracuse 1978. Subspecialty, endocrinology. Board certified (IM); board eligible (M). Group or partnership (both specialties). Available July 1984.

H.L. Kirschenbaum, M.D., 780 Woolley Ave., Staten Island, NY 10314. New York Medical College 1977. Board eligible. Also, gastroenterology. Partnership, group, full-time hospital. Available July 1984.

Andrew L. Saporito, Jr., M.D., 28 Grandview Ave., West Orange, NJ 07052. Guadalajara (Mexico) 1976. Group or partnership. Available.

Mark F. Tsai, M.D., 1715 Stanford Dr., Columbia, MO 65201. National Taiwan University 1977. Also, gastroenterology. Board certified. Available July 1984.

Steven Wolinsky, M.D., 1404 E. 15 St., Brooklyn, NY 11230. Case Western Reserve 1980. Group or partnership. Available July 1984.

NEPHROLOGY—Arvind Mehta, M.D., 8051 N. Hanover St., Anaheim, CA 92861. Seth G.S. Medical College (India) 1975. Also, internal medicine. Board eligible. Solo, group, partnership. Available.

NEUROLOGY—Elizabeth Kamenar, M.D., 12701 Shaker Blvd., Apt. 410, Cleveland, OH 44120. Ohio State 1975. Board eligible. Group, partnership, academia. Available July 1984.

Robert P. Rubens, M.D., 105 Ward St., Apt. 204, Seattle, WA 98109. UMDNJ-New Jersey Medical School 1980. Board eligible. Available July 1984.

OBSTETRICS/GYNECOLOGY—Alan M. Askinas, M.D., 1309 Carrollton, Apt. 321, Metairie, LA 70005. Illinois 1980. Board eligible. Group, partnership, solo, part academia. Available July 1984.

OPHTHALMOLOGY—Steven R. Davis, M.D., 1000 Lakeview Rd., Clearwater, FL 33516. University of Alabama 1975. Board certified. Solo or association. Available.

Andrew Gewirtz, M.D., 519 Beach 133 St., Belle Harbor, NY 11694. Chicago 1978. Board eligible. Board certified (PD). Group or partnership. Available July 1984.

218th Annual Meeting
May 2-6, 1984

Resorts International
Atlantic City, New Jersey

Daily Schedule

Wednesday, May 2, 1984
3:30 p.m.—Board of Trustees' Meeting
7:00 p.m.—Officers' Cocktail Reception followed by Dinner

Thursday, May 3, 1984
9:00 a.m.—Registration Opens
2:00 p.m.—House of Delegates
4:00 p.m.—Reference Committees (Three Reference Committee Meetings)

Friday, May 4, 1984
7:30 a.m.—Registration Opens
9:00 a.m.—House of Delegates (election)
9:00 a.m.—Message Center, and Scientific, Informational, and Insurance Exhibits Open
12:00 noon—Golden Merit Award Ceremony followed by Reception
2:30 p.m.—Reference Committees (Three Reference Committee Meetings)
5:00 p.m.—JEMPAC Political Forum
5:45 p.m.—JEMPAC Wine & Cheese Reception

Saturday, May 5, 1984
8:00 a.m.—Registration Opens
9:00 a.m.—Message Center, and Scientific, Informational, and Insurance Exhibits Open
9:00 a.m.—Scientific Sessions
12:00 noon—Luncheons
1:00 p.m.—Scientific Sessions
6:30 p.m.—Inaugural Reception followed by Inaugural Dinner

Sunday, May 6, 1984
6:30 a.m.—County Society Breakfast Caucuses
8:00 a.m.—Registration Opens
9:00 a.m.—Message Center, and Scientific, Informational, and Insurance Exhibits Open
9:00 a.m.—House of Delegates
3:00 p.m.—Board of Trustees' Meeting

PATHOLOGY—Mark A. Grathwhol, M.D., 2510 West Tremont Ct., Richmond, VA 23225. NYU 1980. Group. Available July 1984.

Yury Kogan, M.D., 60 Egmont St., Brookline, MA 02146. Moscow 1967. Hospital or group. Available July 1984.

PEDIATRICS—Jonathon J. Evans, M.D., 1800 Calvin Ct., #6, Iowa City, IA 52240. Univ. of California-San Diego 1981. Board eligible. Group or HMO. Available July 1984.

Kusumam Sidharthan, M.D., 222 Yorkshire Ct., Old Bridge, NJ 08857. Calicut Medical College (India) 1976. Board eligible. Available July 1984.

PSYCHIATRY—Eric M. Levin, M.D., 43 West 8th St., Media, PA 19063. La Faculté Libre de Medicine (Spain) 1980. Board eligible. Group, institutionally based, CMH outpatient. Available July 1984.

PULMONARY DISEASES—James Kohan, M.D., 19 Highmanor Dr., Henrietta, NY 14467. Virginia 1979. Also, general internal medicine. Board certified (IM). Group, partnership, solo, institutional. Available July 1984.

Dinesh Talati, M.D., 66-02 Grand Central Pkwy., Forest Hills, NY 11375. B.J. Medical College (India) 1974. Board eligible. Solo, group, partnership. Available July 1984.

RADIOLOGY/NUCLEAR MEDICINE—Conrad P. Erlich, M.D., 1243 Beacon St., Apt. 3B, Brookline, MA 02146. Boston 1976. Board certified. Group or partnership. Available July 1984.

Mindy M. Horrow, M.D., 131 Pond Brook Rd., Chestnut Hill, MA 02167. Medical College of Pennsylvania 1980. Board eligible. Group, HMO, academia. Available.

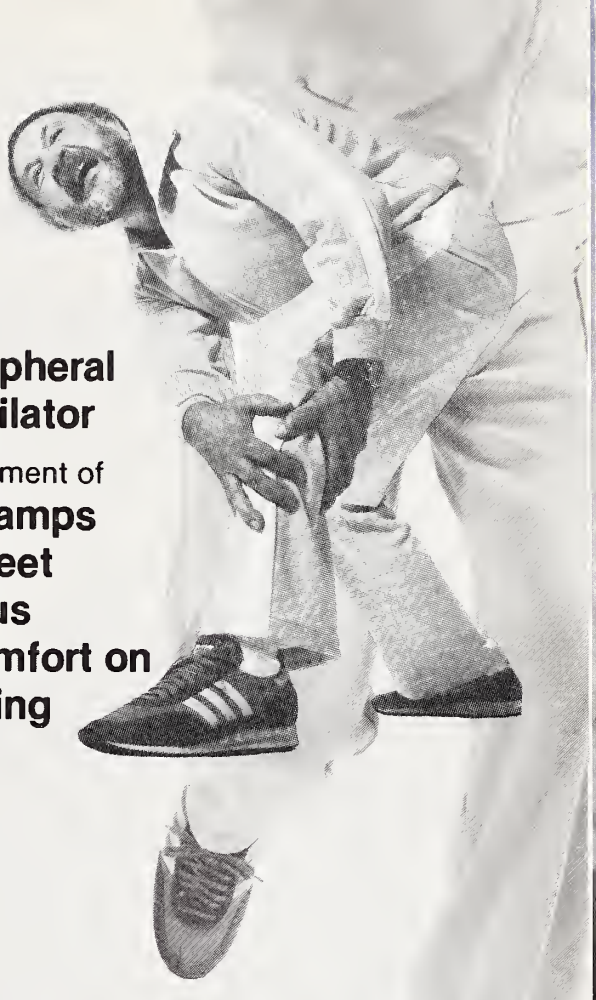
RHEUMATOLOGY—Richard Furie, M.D., 435 E. 70th St., Apt. 8-F, New York, NY 10021. Cornell 1979. Also, general internal medicine. Board certified (IM). Group, partnership, solo. Available July 1984.

SURGERY, GENERAL—F. Andrew Morfesis, M.D., 7545 Rogers Ave., Upper Darby, PA 19082. Penn State (Hershey) 1979. Board eligible. Available July 1984.

SURGERY, ORTHOPEDIC—Jeffrey H. Charen, M.D., 155 Lexington St., Apt. 15, Auburndale, MA 02166. Rochester 1978. Board eligible. Group, partnership, solo (central or northern NJ preferred). Available.

Richard Lebovicz, M.D., 415 Grand St., New York, NY 10002. SUNY-Downstate 1979. Group or partnership. Available July 1984.

UROLOGY—Joseph G. Colonna, M.D., 1234 Van Voorhis Rd., Apt. C-6, Morgantown, WV 26505. Guadalajara (Mexico) 1977. Board eligible. Group or partnership. Available October 1984.



A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release
LIPO-NICIN®/300 mg.

Each time-release capsule contains:
Nicotinic Acid .....300 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) ..... 25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release
LIPO-NICIN®/250 mg.

Each yellow tablet contains:
Nicotinic Acid .....250 mg.
Niacinamide .....75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) ..... 25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide .....75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

Housing Application

218th ANNUAL MEETING
THE MEDICAL SOCIETY OF NEW JERSEY

MAY 3-6, 1984

	Single	Twin	Suites
Resorts International (headquarters hotel)	$80.00	$80.00	$171/$250
Harrah's Marina Hotel Casino	$75.00	$75.00	
World International Hotel/Motel	$58.00	$58.00	
Lafayette Motor Inn	$58.00	$58.00	

Rates subject to 12% state and local taxes; tax subject to change.

All hotel reservations for the 218th Annual Meeting of MSNJ will be handled by the Atlantic City Convention Bureau. Please send your housing application with your 1st, 2nd, and 3rd choices directly to the Bureau, 16 Central Pier, Atlantic City, NJ 08401. All Delegates and Members are urged to make their hotel reservations early. Blocks of rooms will be available at Resorts International (headquarters hotel), Lafayette Motor Inn, World International Hotel/Motel, and Harrah's Marina Hotel Casino. The cut-off date for reservations will be April 6, 1984. Reservations cannot be guaranteed after this date. No Saturday arrivals please. All registrants will be charged for three nights: Thursday, Friday, and Saturday, May 3, 4, and 5, 1984.

MAIL THIS APPLICATION DIRECTLY TO THE ATLANTIC CITY CONVENTION BUREAU
16 Central Pier
Atlantic City, NJ 08401

Please list 1st, 2nd, and 3rd choices; confirmation will come directly from hotel.

1st Choice _____ 2nd Choice _____

3rd Choice _____

Accommodations desired: ☐ Single ☐ Twin ☐ Suite Parlor & 1 Bedroom
☐ Suite Parlor & 2 Bedrooms

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

Will arrive _____ (date) Time _____ Will depart _____ (date) Time _____

☐ Check if Official Delegate _____ County _____

Report of the Nominating Committee

Offices To Be Filled By Election—1984 Annual Meeting

Office	Term	Nominee and County
President-Elect	1 year	Ralph J. Fioretti, M.D., Bergen
First Vice-President	1 year	Edward A. Schauer, M.D., Monmouth
2nd Vice-President	1 year	Harry M. Carnes, M.D., Camden
Trustees:		
1st District	3 years	Douglas M. Costabile, M.D., Union
1st District	3 years	Bernard Robins, M.D., Essex
2nd District	3 years	Carl Restivo, Jr., M.D., Hudson
2nd District	3 years	Gerald H. Rozan, M.D., Passaic
3rd District	3 years	Michael M. Heeg, M.D., Mercer
3rd District	3 years	Palma E. Formica, M.D., Middlesex
4th District	3 years	John P. Kengeter, M.D., Ocean
Judicial Councilors:		
3rd District	1 year	Frank Campo, M.D., Mercer
1st District	3 years	Edward M. Coe, M.D., Union
4th District	3 years	Frederick W. Durham, Camden
AMA Delegates:		
	2 years	Alfred A. Alessi, M.D., Bergen
	2 years	Frederick W. Durham, M.D, Camden
	2 years	Palma E. Formica, M.D., Middlesex
	2 years	Karl T. Franzoni, M.D., Mercer
	2 years	John S. Madara, M.D., Salem
	2 years	Henry J. Mineur, M.D., Union
AMA Alternate Delegates:		
	½ year*	Joseph A. Riggs, M.D., Camden
	2 years	Joseph A. Riggs, M.D., Camden
	2 years	Augustus L. Baker, Jr., M.D., Morris
	2 years	Charles S. Krueger, M.D., Burlington
	2 years	Carl A. Restivo, Sr., M.D., Hudson
	2 years	Robert H. Stackpole, M.D., Union
Delegates and Alternate Delegates to Other States:		
New York:		
Delegate	1 year	F. Sterling Brown, M.D., Atlantic
Alternate	1 year	John J. Pastore, M.D., Cumberland
Connecticut:		
Delegate	1 year	Frank R. Romano, Sr., M.D., Union
Alternate	1 year	Gastone A. Milano, M.D., Altantic
Administrative Councils:		
Legislation:		
5th District	3 years	L. Willis Allen, M.D., Cumberland
6th Member	3 years	Howard H. Lehr, M.D., Union
Medical Services:		
5th District	3 years	John J. Pastore, M.D., Cumberland
6th Member	3 years	Frank A. Wolf, M.D., Warren
Mental Health:		
3rd District	3 years	Joseph J. Kline, M.D., Mercer
6th Member	3 years	William R. Nadel, M.D., Union
Public Health:		
5th District	3 years	Narasimhaloo Venugopal, M.D., Cumberland
6th Member	3 years	Glenn P. Lambert, M.D., Hunterdon
Public Relations:		
2nd District	3 years	Joseph W. Bitsack, M.D., Bergen
5th District	3 years	John J. Pastore, M.D., Cumberland
Standing Committees:		
Annual Meeting	3 years	Thomas J. Connolly, Jr., M.D., Hudson
Auxiliary Advisory	3 years	J. James Pegues, M.D., Burlington
Finance and Budget	3 years	Harry M. Carnes, M.D., Camden
Medical Defense and Insurance	3 years	E. Arthur Kratzman, M.D., Union
Medical Education	3 years	Edwin W. Messey, M.D., Burlington
Publication	3 years	Dirck L. Brendlinger, M.D., Burlington

*Unexpired term of Daniel J. O'Regan, M.D., deceased

ANNUAL AWARDS DINNER

of

THE ACADEMY OF MEDICINE OF NEW JERSEY

Wednesday, May 23, 1984
6:00 P.M.

at
THE CHANTICLER
Short Hills, New Jersey

1984 AWARD RECIPIENTS

EDWARD J. ILL AWARD
ALFRED A. ALESSI, M.D.

CITIZENS AWARD
CONGRESSMAN JAMES COURTER
(R-12th District)

For further information, please contact:

The Academy of Medicine of New Jersey

EXECUTIVE OFFICES
The Academy of Medicine of New Jersey
Two Princess Road
Lawrenceville, NJ 08648
(609) 896-1717

June 16, 1984

4th Annual Advances in Gastroenterology

Golden Nugget Hotel
Atlantic City, New Jersey

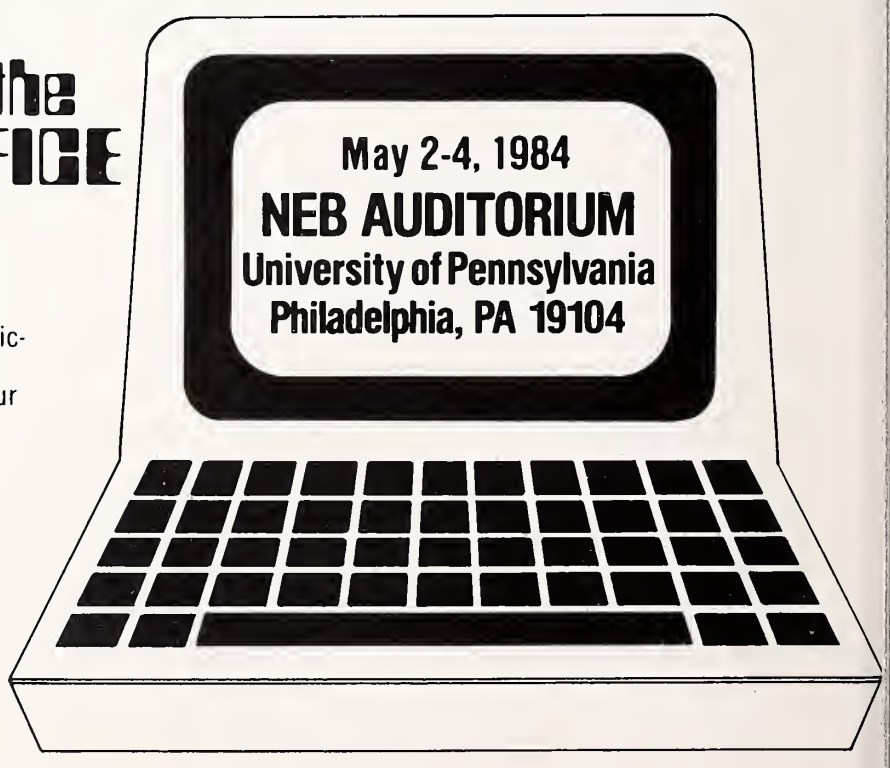
Sponsored by the Gastrointestinal Section
of the Hospital of the
University of Pennsylvania
and
the Continuing Medical Education
Department of the
Underwood Memorial Hospital
Woodbury, New Jersey

Category 1 credit offered

Information: Registration Supervisor, SLACK Incorporated, 6900 Grove Road, Thorofare, New Jersey 08086, 609-848-1000

University of Pennsylvania
School of Medicine

AUTOMATION of the PHYSICIAN'S OFFICE



Course Director: Patrick B. Storey, M.D.
Associate Dean for Continuing
Medical Education

A 3-day program that will provide you, the practicing physician, with the information you need to make informed judgments about automating your office.

Approved for 18 Category 1 credit hours of the Physician's Recognition Award of the American Medical Association and 18 prescribed hours by the AAFP.

For further information, contact:
Nancy Wink, Program Director
Continuing Medical Education
(215) 898-8005

CME CALENDAR

The following is a list of continuing medical education courses for the next two months. Contact the sponsoring organization for further information.

This list is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the UMDNJ. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

May

1, 8, 15, 22 **Anesthesia Lectures**
4-5 P.M.—NJ Medical School, Newark
(UMDNJ)

2, 9, 16, 23, 30 **Anesthesia Grand Rounds**
4-5 P.M.—University Hospital, Newark
(UMDNJ)

7, 14, 21 **Anesthesia Lectures**
7-8 A.M.—NJ Medical School, Newark
(UMDNJ)

June

4, 11, 18, 25 **Anesthesia Lectures**
7-8 A.M.—NJ Medical School, Newark
(UMDNJ)

5, 12, 19, 26 **Anesthesia Lectures**
4-5 P.M.—NJ Medical School, Newark
(UMDNJ)

6, 13, 20, 27 **Anesthesia Grand Rounds**
4-5 P.M.—University Hospital, Newark
(UMDNJ)

CARDIOLOGY

May

1, 9, 16, 23, 30 **Vascular Conference**
4-5 P.M.—NJ Medical School MSB C 600
(UMDNJ)

2 **Recent Advances in Echocardiology**
1-2:30 P.M.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

2 **Cardiovascular Evaluation and Treatment of Patients with Recurrent Syncope**
9-11 P.M.—Middlesex General Hospital, New Brunswick
(Middlesex General-University Hospital and AMNJ)

5, 6 **Advanced Echocardiography**
9 A.M.-5 P.M.—Center for Health Affairs, Princeton
(The National Foundation for Non-invasive Diagnostics and AMNJ)

9, 23 **Preventive Cardiology Seminar**
12 noon-1 P.M.—NJ Medical School, Newark
(UMNDJ)

19 **Prosthetic Cardiac Valves**

20 **Summary of M-Mode, 2D, and Doppler Echo Features for Acquired and Congenital Cardiac Lesions**
9 A.M.-5:30 P.M.—Nassau Inn, Princeton
(Practical Diagnostic Ultrasound Seminars and AMNJ)

June

6, 20 **Preventive Cardiology Seminar**
12 noon-1 P.M.—NJ Medical School, Newark
(UMDNJ)

6, 13, 20, 27 **Vascular Conference**
4-5 P.M.—NJ Medical School, Newark
(UMDNJ)

6 **Cardiac Arrhythmias**
1-2:30 P.M.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

MEDICINE

May

1 **Strokes, C.V.A.—Post and Rehab Care**
11 A.M.-12 noon—Greystone Park Psychiatric Hospital
(Greystone Park Psychiatric Hospital and AMNJ)

2 **Medical Grand Rounds**
11:30 A.M.—VA Medical Center, East Orange
(Endocrinology Section, AMNJ)

2 **Alcoholism**
1:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)

2 **William P. Burpeau Award Dinner and Memorial Lecture**
6:30 P.M.—The Manor, West Orange
(Urology Section, AMNJ)

2 **Occupational Medicine for the Primary Physician**

30 **Cancer Emergencies**
1:30-2:30 P.M.—Rutgers Community Health Plan, 57 U.S. Hwy. #1, New Brunswick
(Rutgers Community Health Plan and AMNJ)

2, 9, 16, 23, 30 **Endocrine Conferences**
3:30-5 P.M.—Rotates between Newark Beth Israel Medical Ctr., University Hospital, Newark, and United Hospitals Medical Ctr., Newark, and VA Medical Ctr., East Orange
(Endocrinology Section, AMNJ)

2, 9, 16, 23, 30 **Rehabilitation Medicine**
4:15-5:15 P.M.—Kessler Institute, West Orange
(UMDNJ)

3, 10, 17, 24, 31 **Digestive Disease I**
8-9 A.M.—NJ Medical School, Newark
(UMDNJ)

3, 10, 17, 24, 31 **Allergy, Immunology Lecture**
11 A.M.-12 noon—Children's Hospital, Newark
(UMDNJ)

3 **Fever of Unknown Origin in the 1980s**

24 **Carcinoma of the Colon**
11 A.M.—St. Joseph's Hospital and Medical Center, Paterson
(St. Joseph's Hospital and Medical Center and AMNJ)

3 **Recurrent Abdominal Pain**
9 A.M.—Freehold Area Hospital
(AMNJ)

3 **Medical Grand Rounds**
9:30 A.M.—Newark Beth Israel Medical Ctr.
(Endocrinology Section, AMNJ)

3 **Chemotherapy**
4-6 P.M.—Institute for Medical Research, Copewood Street, Camden
(Institute for Medical Research and AMNJ)

3-6 **218th Annual Meeting**
Resorts International, Atlantic City
(Medical Society of New Jersey and AMNJ)

4 **Medical Grand Rounds**
11:30 A.M.—University Hospital, Newark
(Endocrinology Section, AMNJ)

4, 18 **Renal Conferences in Nephrology**
4-5 P.M.—UMDNJ-University Hospital, Newark
(Nephrology Society of NJ and Nephrology Section, AMA)

4, 11, 18, 25 **Dept. of Medicine Grand Rounds**
11:30 A.M.-1 P.M.—NJ Medical School, Newark
(UMDNJ)

4 **Grand Rounds in Rehabilitation**
1:30-2:30 P.M.—Rotates between University Hospital, Newark, Kessler Institute, West Orange, and Children's Specialized Hospital, Westfield
(UMDNJ)

4, 11, 18, 25 **Urology Grand Rounds**
3-5 P.M.—NJ Medical School, Newark
(UMDNJ)



LIKOFF CARDIOVASCULAR INSTITUTE
of Hahnemann Medical College & Hospital
230 N. Broad Street, Philadelphia, Pennsylvania 19102 (215) 448-8063

CARDIOLOGY UPDATE. . .

IS DESIGNED FOR THE PHYSICIAN AND PROVIDES AN INTENSIVE SURVEY OF THE CURRENT STATUS OF CLINICAL CARDIOLOGY. . .

WEDNESDAY, MAY 2, 1984

CORONARY ARTERY BYPASS GRAFTING

Moderator: Bernard L. Segal, M.D.

3:00 Case Presentation/**Stanley Spitzer, M.D.**

3:30 Coronary Artery Surgery for Patients with Single, Double, and Triple Coronary Vessel Disease: Indications and Results/**Bernard L. Segal, M.D.**

4:00 Coronary Artery Vasoconstriction: Etiology Assessment and Management/ **Charles E. Bemis, M.D.**

4:30 Rehabilitation of the Patient After Coronary Bypass/**David T. Lowenthal, M.D.**

5:00 The Management of Patients with Recurrent Angina After Coronary Bypass Operation/**Morris N. Kotler, M.D.**

5:30 Panel Discussion

LECTURE HALL "A"—2nd floor New College Building, Hahnemann University
15th and Vine Streets, Philadelphia, PA

• NO REGISTRATION FEE • NO ADVANCE REGISTRATION REQUIRED •
• CME CATEGORY I CREDITS CERTIFIED •

WINE & CHEESE SERVED FOLLOWING EACH SESSION

8 **Principles of Hyperalimentation in Trauma Patients**
7-9 A.M.—Hackensack Medical Center
(Hackensack Medical Center and AMNJ)

9 **Glycosylated Hemoglobin and Home Glucose Monitoring**
1-2:30 P.M.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

15 **Newer Concepts in CPR**
12:00 noon—St. Mary's Hospital, Orange
(AMNJ)

15 **Drugs and Water Metabolism**
4-5 P.M.—Academic Health Science Ctr., Rm. 393, New Brunswick
(UMDNJ and AMNJ)

15 **Renal Hormone Resistant States**
7-8 P.M.—Ramada Inn, Clark
(Nephrology Society of NJ and AMNJ)

15 **AIDS/Herpes**
29 **Clinical Treatment of Headache**
11 A.M.-12 noon—Greystone Park Psychiatric Hospital
(Greystone Park Psychiatric Hospital and AMNJ)

15 **IVP Conference**
5-7 P.M.—East Orange VA Hospital
(UMDNJ)

16 **Interhospital Rheumatology Rounds**
4:30-6 P.M.—University Hospital, Newark
(UMDNJ)

16 **Drugs, Alcohol, and Pregnant Women**
8:30 A.M.-3:15 P.M.—Monmouth Medical Ctr., Long Branch
(Div. of Alcoholism, NJ State Dept. of Health, and AMNJ)

16 **Dermatological Conferences**
6-9 P.M.—Rutgers Community Health Plan, 57 U.S. Hwy. #1, New Brunswick
(UMDNJ-Rutgers Medical School and AMNJ)

16 **Modern Medical Genetics**
23 **Diseases of Mucous Membrane**
10:30-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

17 **Newer Concepts in Sarcoidosis**
5-6:30 P.M.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

Clinical Concerns in Hemodialysis Patients
18 8:15 A.M.-5 P.M.
19 8 A.M.-1 P.M.—New York Hilton Hotel, New York City
(Nephrology Society of NJ and AMNJ)

30 **Gastrointestinal Bleeding**
10:30 A.M.-12 noon—St. Mary's Hospital, Passaic
(AMNJ)

30 **Hepatic Metabolic Complications of Alcoholism**
1-2:30 P.M.—VA Medical Ctr., Lyons Bldg. 93
(VA Medical Ctr. and AMNJ)

31 **How To Live To Be 100**
11 A.M.—St. Joseph's Hospital and Medical Center, Paterson
(St. Joseph's Hospital and Medical Center and AMNJ)

June

1 **Urology Grand Rounds**
8 3-5 P.M.—NJ Medical School, Newark
15 *(UMDNJ)*
22
29

1 **Renal Conferences in Nephrology**
15 4-5 P.M.—University Hospital, Newark
(Nephrology Society of NJ and Nephrology Section, AMNJ)

1 **Grand Rounds in Rehabilitation**
1:30-2:30 P.M.—Rotates between University Hospital, Newark, Kessler Institute, West Orange, and Children's Specialized Hospital, Westfield
(UMDNJ)

1 **Dept. of Medicine Grand Rounds**
8 11:30 A.M.-1 P.M.—NJ Medical
15 School, Newark
22 *(UMDNJ)*
29

6 **Endocrine Conferences**
13 3:30-5 P.M.—Rotates between
20 Newark Beth Israel Medical
27 Center, University Hospital, Newark, and United Hospitals Medical Ctr., Newark, and VA Medical Center, E. Orange
(Endocrinology Section, AMNJ)

6 **Rehabilitation Medicine**
13 4:15-5:15 P.M.—Kessler Institute,
20 West Orange
27 *(UMDNJ)*

6 **Medical Grand Rounds**
11:30 A.M.—VA Medical Ctr., East Orange
(Endocrinology Section, AMNJ)

6 **Gastrointestinal Bleeding**
1:30-2:30 P.M.—Essex County Hospital, Cedar Grove
(Essex County Hospital and AMNJ)

6 **Therapeutic Controversies in GI Diseases**
1:30-5 P.M.—Saint Barnabas Medical Ctr., Livingston
(NJ Gastroenterological Society and AMNJ)

6 **Common Allergy Problems**
20 **Inflammatory Bowel Disease**
1:30-2:30 P.M.—Rutgers Community Health Plan, 57 U.S. Hwy. 1, New Brunswick
(Rutgers Community Health Plan and AMNJ)

7 **Digestive Disease I**
14 8-9 A.M.—NJ Medical School,
21 Newark
28 *(UMDNJ)*

7 **Digestive Diseases II**
14 9-10 A.M.—NJ Medical School,
21 Newark
28 *(UMDNJ)*

7 **Allergy, Immunology Lecture**
14 11 A.M.-12 noon—Children's
21 Hospital, Newark
28 *(UMDNJ)*

7 **Management of Short Stature**
9 A.M.—Freehold Area Hospital
(AMNJ)

7 **Medical Grand Rounds**
9:30 A.M.—Newark Beth Israel Medical Center
(Endocrinology Section, AMNJ)

7 **Irritable Bowel Syndrome**
11 A.M.—St. Joseph's Hospital and Medical Center, Paterson
(St. Joseph's Hospital and Medical Center and AMNJ)

8 **Medical Grand Rounds**
11:30 A.M.—UMDNJ-University Hospital, Newark
(Endocrinology Section, AMNJ)

12 **Fluid and Electrolyte Imbalance**
11 A.M.-12 noon—Greystone Park Psychiatric Hospital
(Greystone Park Psychiatric Hospital and AMNJ)

14 **Rheumatology Update**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

19 **Continuous Arteriovenous Hemofiltration**
4-5 P.M.—Academic Health Science Center, New Brunswick
(UMDNJ and AMNJ)

19 **IVP Conference**
5-7 P.M.—East Orange VA Hospital
(UMDNJ)

20 **Interhospital Rheumatology Rounds**
4:30-6 P.M.—University Hospital, Newark
(UMDNJ)

20 **Pathogenesis, Diagnosis, and Management of Type II Diabetes**
1-2:30 P.M.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

20 **Dermatological Conference**
6-9 P.M.—Rutgers Community Health Plan, 57 U.S. Hwy. 1, New Brunswick
(UMDNJ and AMNJ)

20 **Cancer of the Colon**
27 **Diabetes Mellitus**
10:30-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

NEUROLOGY/PSYCHIATRY

May

2 **Epilepsy—Classification and New Treatment**
10:30 A.M.-12 noon—St. Mary's Hospital, Passaic
(AMNJ)

2 **Group Therapy**
16 2-3 P.M.—Ancora Psychiatric
30 Hospital
(Ancora Psychiatric Hospital and AMNJ)

2 **Grand Rounds in Psychiatry**
10:30 A.M.-12 noon—NJ Medical School, Newark
(UMDNJ)

3 **The Hypochondriacal Patient**
10 **Adolescents and Families with Drug and Alcohol Problems**
17 **Medication Treatment of Phobias**
31 **ECT: Sine *v* Pulse Wave and Other New Developments**

12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

4, 11, 18, 25 **Psychiatric Lecture Series**
1:30-5 P.M.—Trenton Psychiatric Hospital
(Trenton Psychiatric Hospital and AMNJ)

7 **Effect of Porno Pictures on Sexual Compulsion of a 5-Year-Old Child**
8:15-10:30 P.M.—9 Marquette Road, Montclair
(Essex Psychiatric Seminar and AMNJ)

7, 14, 21, 28 **Psychotherapies**
1-3 P.M.—Ancora Psychiatric Hospital
(Ancora Psychiatric Hospital and AMNJ)

9 **Convulsive Seizures**
1-2:30 P.M.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

15, 16 **Adolescent Health and Illness**
9 A.M.-5:00 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

16 **Lecture in Psychiatry**
10:30 A.M.-12 noon—NJ Medical School, Newark
(UMDNJ)

16 **Psychiatry Lecture**
1-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(UMDNJ)

17 **Aspects of Manic-Depressive Illness**
8-10 P.M.—Hackensack Medical Ctr.
(NJ Psychoanalytic Society and AMNJ)

21 **Principles of Child Psychotherapy**
8:30-10:30 P.M.— 301 Broad St., Englewood
(NJ Psychoanalytic Society and AMNJ)

22 **Family Therapies**
1-3 P.M.—Ancora Psychiatric Hospital
(Ancora Psychiatric Hospital and AMNJ)

23 **Alarming Growth of Teen-age Suicides**
All day—Holiday Inn, North Brunswick
(NJ Department of Health and NJ Public Health Assn.)

June

1, 8, 15 **Psychiatric Lecture Series**
1:30-5 P.M.—Trenton Psychiatric Hospital
(Trenton Psychiatric Hospital and AMNJ)

4 **Depression in a Patient**
8:15-10:30 P.M.—1046 So. Orange Ave., Short Hills
(Essex Psychiatric Seminar and AMNJ)

4, 11 **Psychotherapies**

25 **Behavior Modification**
1-3 P.M.—Ancora Psychiatric Hospital, Hammonton
(Ancora Psychiatric Hospital and AMNJ)

6 **Grand Rounds in Psychiatry**
10:30 A.M.-12 noon—NJ Medical School, Newark
(UMDNJ)

6 **Psychoneuroimmunology**
9:30 A.M.-5 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

6 **Group Therapy**
2-3 P.M.—Ancora Psychiatric Hospital, Hammonton
(Ancora Psychiatric Hospital and AMNJ)

7 **Calcium Channel Blockers in the Brain**

21 **Adolescents and Families with Drug and Alcohol Problems**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

9 **Problem Behaviors in Adolescence**
8 A.M.-3:30 P.M.—NJ Medical School, Newark
(UMDNJ, NJ Council of Child and Adolescent Psychiatry, and AMNJ)

18 **Principles of Child Psychotherapy**
8:30-10:30 P.M.—301 Broad Ave., Englewood
(NJ Psychoanalytic Society and AMNJ)

20 **Lecture in Psychiatry**
10:30 A.M.-12 noon—NJ Medical School, Newark
(UMDNJ)

20 **Psychiatry Lecture**
1-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(UMDNJ)

21 **Update of Clinical Psychiatry**
12 noon-4:30 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

21 **The Many Faces of Clinical Depression**
5-6:30 P.M.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

OBSTETRICS/GYNECOLOGY

May

2 **Ob/Gyn Lecture**
7-8 P.M.—L'Affair Restaurant, Mountainside
(UMDNJ)

PATHOLOGY

May

9 **Pathology Grand Rounds**
10:30-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

10, 24 **Pathology Seminars**
12 noon-1 P.M.—NJ Medical School, Newark
(UMDNJ)

June

13 **Pathology Grand Rounds**
10:30-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

14 **Pathology Seminar**
12 noon-1 P.M.—NJ Medical School, Newark
(UMDNJ)

PEDIATRICS

May

4, 11, 18, 25 **Advances in Pediatrics**
9:30-10:30 A.M.—NJ Medical School, Newark
(UMDNJ)

10 **Pediatric Malignant Diseases**
4-6 P.M.—Institute for Medical Research, Copewood Street, Camden
(Institute for Medical Research and AMNJ)

18 **Changing Concepts in the Treatment of Seizures**
8-9:30 A.M.—Overlook Hospital, Summit
(Overlook Hospital and AMNJ)

21 **Outcome of High-Risk Infants**
12 noon-1 P.M.—The Mountainside Hospital, Montclair
(The Mountainside Hospital and AMNJ)

June

1, 8, 15, 22, 29 **Advances in Pediatrics**
9:30-10:30 A.M.—NJ Medical School, Newark
(UMDNJ)

8 **AIDS in Children**
8-9:30 A.M.—Overlook Hospital, Summit
(Overlook Hospital and AMNJ)

18 **Practical Aspects of Pediatric Toxicology**
12 noon-1 P.M.—The Mountainside Hospital, Montclair
(The Mountainside Hospital and AMNJ)

RADIOLOGY

May

9 **Radiology Grand Rounds**
23 2-4 P.M.—University Hospital, Newark
(UMDNJ)

16 **Dinner Meeting**
6:30 P.M.—The Manor, West Orange
(Radiotherapy Section, AMNJ)

17 **Combined Meeting**
7:30-10 P.M.—Saint Barnabas Medical Ctr., Livingston
(NJ Institute of Ultrasound, Radiological Society of NJ, and Diagnostic Radiology Section, AMNJ)

23 **CT Conference**
4-6 P.M.—University Hospital, Newark
(UMDNJ)

24 **Forensic Radiology**
1:30-5 P.M.—Saint Barnabas Medical Ctr., Livingston
(Saint Barnabas Medical Ctr. and AMNJ)

June

6 **Radiology Grand Rounds**
20 2-4 P.M.—University Hospital,

Newark
(UMDNJ)

27 **CT Conference**
4-6 P.M.—University Hospital, Newark
(UMDNJ)

SURGERY

May

2 **Surgical Departmental**
9 **Conferences**
16 8:30-10 A.M.—Rutgers Medical
23 School, Medical Education Bldg.,
30 New Brunswick
(UMDNJ and AMNJ)

5 **Surgical Morbidity and Mortality**
12 **Conference**
19 8:30-10 A.M.—NJ Medical School,
26 Newark
(UMDNJ)

7 Surgical Grand Rounds/Lecture
14 Series
21 4:30-5:30 P.M.—NJ Medical School, Newark
(UMDNJ)

16 **Common Outpatient Surgical Problems**
1:30-2:30 P.M.—Community Health Plan, New Brunswick
(Rutgers Community Health Plan and AMNJ)

30 **Surgical Nutrition**
1-2:30 P.M.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

June

2 **Surgical Morbidity and Mortality**
9 **Conference**
16 8:30-10 A.M.—NJ Medical School,
23 Newark
30 *(UMNDJ)*

4 **Surgical Grand Rounds/Lecture**
11 **Series**
18 4:30-5:30 P.M.—NJ Medical School,
25 Newark
(UMDNJ)

6 **Surgical Departmental**
13 **Conference**
20 8:30-10 A.M.—Rutgers Medical School, Medical Education Bldg., New Brunswick
(UMDNJ and AMNJ)

SURGICAL SPECIALTIES

May

2 **Management of Lacrimal Drainage Problems**
7:30-9:30 P.M.—Saint Barnabas Medical Ctr., Livingston
(AMNJ)

3 **Vascular Surgical Rounds**
10 4-5 P.M.—Rutgers Medical School,
17 Medical Education Bldg., New
24 Brunswick
31 *(UMDNJ and AMNJ)*

4 **Cancer Research Colloquium**
11 12 noon-1 P.M.—University
18 Hospital, Newark
25 *(UMDNJ)*

5 **Surgical Treatment of Cardiothoracic Diseases**
10-11:30 A.M.—NJ Medical School, Newark
(UMDNJ)

7 **Tumor Conference**
14 8-9 A.M.—University Hospital,
21 Newark
(UMDNJ)

16 **Eye Institute Grand Rounds**
7-9 P.M.—United Hospital Annex Bldg., Newark
(UMDNJ)

17 **Neurosurgery Lecture**
4-5 P.M.—University Hospital, Newark
(UMDNJ)

June

1 **Cancer Research Colloquium**
18 12 noon-1 P.M.—University Hospital
15 F467
22 *(UMDNJ)*
29

2 **Surgical Treatment of Cardiothoracic Diseases**
10-11:30 A.M.—NJ Medical School, Newark
(UMDNJ)

4 **Tumor Conference**
11 8-9 A.M.—University Hospital,
18 Newark
25 *(UMDNJ)*

7 **Vascular Surgical Rounds**
14 4-5 P.M.—Rutgers Medical School,
21 Medical Education Bldg., New
28 Brunswick
(UMDNJ and AMNJ)

19 **Surgical Treatment of Morbid Obesity**
12 noon—St. Mary's Hospital, Orange
(AMNJ)

20 **Eye Institute Grand Rounds**
7-9 P.M.—United Hospital Annex Bldg.
(UMDNJ)

21 **Neurosurgery Lecture**
4-5 P.M.—University Hospital, Newark
(UMDNJ)

MISCELLANEOUS

May

1 **Computers in Medicine**
7:30 P.M.—Burdette Tomlin Mem. Hosp., Cape May Court House
(AMNJ)

10 **Patient Advocacy Issues Two Years Later**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

LETTERS TO THE EDITOR

Presidential Column; Dr. Harrison Martland; Reorganization of Hospital Staffing; The Law of the Duck

Presidential Column

December 30, 1983

Dear Doctor Krosnick:

After reading Dr. Kovacs's presidential column in the December issue of *The Journal*, MSNJ, I had feelings of uncertainty.

The situations he outlined were those we have read and reread in the *AMA News* and the various printed media confronting us t.i.d.

In ending his essay, Dr. Kovacs states that time is running out on our "having an opportunity to become an active participant in the newly evolving practices of medicine" else we become a "fully regulated and controlled public utility."

In the last paragraph, he reminds us that "our position is (not) a weak one" and that we "can still effect benefical change if we unite for that purpose."

Early on, Dr. Kovacs actively embraced participation in a local HMO-IPA. This form of organization is thought by many physicians to be adverse to the best interests of both patient and doctor in the context of independent private practice.

Before we energetically unite under Dr. Kovacs's leadership, I hope he will devote his next column to letting us know specifically to which programs and changes he would commit us.

(signed) Albert Minzter, M.D.

Dr. Harrison Martland

January 19, 1984

Dear Doctor Krosnick:

The cover photograph on the January 1984 issue of *The Journal* is incredibly insensitive, tasteless, and ironic.

As physicians, the implicit approval of smoking in the photograph at a time when we know the effects on heart disease and cancer is appalling.

The insensitivity of the cigarette ashes dangling and about to fall on the remains of a cadaver is obvious.

I am embarrassed for the Society and the profession.

(signed) James Bellet, M.D.

Editor's Response: The cover photograph on the January 1984 issue of *The Journal* is a picture of Dr. Harrison Martland, who was appointed pathologist to Newark City Hospital in 1908. The photograph was made available to us from the Archives of UMDNJ, George F. Smith Library, in Newark. Those who knew Dr. Martland have told me that the cover likeness is absolutely typical of the very colorful man.

The use of the picture of the scientist whose work was reviewed in the Medical History article in the same issue is both logical and fair, in my opinion.

I disagree that this cover gives "implicit approval of smoking." I do not smoke, nor do I allow smoking in my home or office. In fact, I have written antismoking articles for *The Journal* which may have prodded the Board to ban smoking at MSNJ meetings. I appreciate and agree with your obvious antismoking demeanor.

The question of "insensitivity to the cigarette ashes dangling" must be overridden by the historical significance of the issue. Cigarette smoking in the first quarter of this century cannot be condemned in the light of present day scientific fact. To accuse the Editor, the Medical Society, or the Publication Committee of insensitivity on the issue seems unfair; that attitude is tantamount to hurling the same accusation at the photographers who daily send back pictures of the antihuman horrors in El Salvador, Lebanon, and elsewhere in this world and at the editors of the newspapers, magazines, and television programs which reproduce them.

History is history and we have no right to censor or distort it to make it conform to some other standards of conduct.

I understand your feelings, but I do not share them on this issue.

January 26, 1984

Dear Doctor Krosnick:

The cover photo on the January 1984 issue of *The Journal* is beautiful and fit for framing except there is no way of removing the mailing address and leaving a clean surface. I desire to send covers to Martland's daughter and two grandsons.

(signed) Samuel Berg, M.D.

Reorganization of Hospital Staffing

February 4, 1984

Dear Doctor Krosnick:

A case is coming to the courts which potentially can change the organization of hospital staffing. Marilyn Wrable, a nurse practicing psychiatric counseling, recently was asked to see a patient of hers hospitalized locally. Hospital rules provided that a nonstaff member may be accorded temporary privileges by cojoint agreement between the president of the medical staff, as well as the administrator on duty. The physician agreed, and the administrator refused to permit an official consultation, but was willing to allow the nurse-counselor to visit her patient unofficially. This incident seeded circumstances which promise to end in the courts, and possibly change the manner in which hospital staffs are organized.

Until recently, hospitals have been the domain of physicians. If physicians did not like a hospital, or conditions were too crowded, or competition too severe, they might find another. This circumstance has been prohibited in New Jersey for a dozen or so years, since the enactment of the certificate of need.

The state has restricted the number of allowable hospital beds. Thus, nonmedical "providers" are seeking hospital privileges in restricted hospital space. Since the number of hospitals now is limited by law, nonmedical providers, some of whom are licensed under one board or another to practice their specialties, will be vying with medical practitioners for medical beds.

Medical staffs will find themselves embroiled with chiropractors, podiatrists, optometrists, physical therapists, and dietitians for bed space and consultation privileges, as these special-interest groups seek hospital privileges.

Hospital staffs currently are restricted to physicians and, in some instances, physicians and dentists.

The courts seem prone to permit or even force the current medical and medical-dental staffs to provide space and supervision for nonmedical specialists.

The professional corporation law in New Jersey permits the banding together of members of one profession to form a professional association; but doctors cannot mingle with dentists, and so forth. The association by law is restricted to the members of one profession only.

Yet, in hospitals, the trend is to create adjunct staffs for the nonmedical groups, under the aegis of the medical staff.

I suggest it would be wiser to follow the precepts of the professional corporation law. All medical staffs should incorporate under this law. This will exclude dentists who can form their own corporations, as can other nonmedical specialty groups. Under the current system, the medical staffs are expected to supervise and take responsibility for the nonmedical adjunct staff members. This responsibility falls beyond the limits of our licensure.

Doctors should divorce themselves from the other groups, incorporate as a professional association, join the hospital on that basis; and then let the hospital decide on the status it wants to grant optometrists, chiropractors, podiatrists, dietitians, and physical therapists who also want staff privileges. None of these should be members of the medical staff because the medical staff is not competent under their license to supervise them, and because the law will not permit mixing of specialties under the professional association act.

Failure of doctors to do this will embroil us continually in litigation, and empower judges and lawyers who have never practiced the art of medicine, to foist upon us responsibilities we neither want nor need.

Our business is medicine; our license is medicine; and we are not to be diverted by a struggle for the hospital turf.

Failing to do this we will find ourselves, already contributing considerable time to hospital management, trying to direct staffs that have been reshaped by the courts.

Retreat is occasionally timely; and I would suggest that now is the time to retreat into the bastion of medicine and let the other armies fight it out with the hospital administrations. Then the hospitals (rather than the doctors) will not only have to deal with these responsibilities, but also be responsible for these dealings.

(signed) Charles Harris, M.D.

The Law of the Duck

February 6, 1984

Dear Doctor Krosnick:

If you talk like a businessman, think like a businessman, and market your wares like a businessman, then it would be reasonable to conclude you are a businessman.

That is—unless you are a doctor. In this instance you become a hybrid; to be considered a responsible professional but not to be regulated as a businessman. That is, according to the AMA.

Somehow, I find that a bit hard to swallow and I suspect, so does the general public. I am afraid that our medical leaders in Chicago will have us believe that, unless we get right out and actively market our medical products and services in this "changing competitive environment," we independent practicing physicians soon will become an endangered species.

I resent that organized medicine has chosen to encourage a physician to conduct his practice of medicine in business-like jargon and promotional schemes. I resent the fact that our professional societies themselves have accepted the verbal and mental syntax of an advertising and marketing agency. I often think that the AMA is trying to stampede us, its membership, into a state of panic in order to play the role of an indispensible shepherd rescuing his flock.

For whose benefit is the AMA spending money to hire a full-time expert to encourage the practicing physicians to market their services in order to increase their business? I believe that when we think of ourselves and our work in these terms we will be assuming the position which the Federal Trade Commission wishes us to adopt.

Let us stop this game of words and images. Let us practice medicine as best we can, with our patients' welfare first and foremost. Let us stop trying to act like tradesmen and, instead, conduct ourselves as physicians.

(signed) Albert Minzter, M.D.

Aesthetic Breast Surgery; Common Skin Disorders; Diabetes: A New Complete Guide to Healthier Living; Disorders of the Hip; Power and the Profession of Obstetrics

Aesthetic Breast Surgery

Nicholas G. Georgiade, M.D. Baltimore, MD, Williams & Wilkins, 1983. Pp. 408. Illustrated. ($69.95)

The preface to this book begins by quoting Robert Browning: "Beauty is in the eye of the beholder." Certainly, no organ is more associated with femininity than the breast, and cosmetic and reconstructive surgery on the breast is performed daily at hospitals throughout the country.

The editor has assembled an international cast of experts to produce a volume of 30 chapters that run the gamut from anatomy and physiology to psychology, but focus, to a great degree, on augmentation and reduction mammoplasty.

There is a plethora of illustrations (black and white) which is mandatory in a book such as this. (Browning was right!) Each chapter concludes with a list of suggested readings. Many of the chapters are devoted to the same subject, e.g. breast augmentation, breast reduction, and the reader can compare among operative procedures espoused by experts from throughout the world.

This is a highly specialized book which will appeal to plastic surgeons, general surgeons, and residents in surgery. However, as an addition to a library it would have a broader audience since so many physicians deal with women with breast diseases and might well be interested in the aesthetic results of the surgery.

Ralph S. Greco, M.D.
UMDNJ-Rutgers Medical School

Common Skin Disorders, 2nd Edition

Ernst Epstein, M.D. Oradell, NJ, Medical Economics Books, 1983. Pp. 280. Illustrated. ($25.95)

This softcover, large format manual is for the nonspecialist. The dermatologist-author provides a simplified, and very personal, view of what the doctor and the patient should know about some of the more common skin problems. The book is a combination folksy-discussion and recipe collection, which explains each condition and its rational management. The initial portion of the volume is directed to the physician, the remaining one-third consists of tear-out patient instruction sheets. These handouts contain easy-to-understand explanations which repeat what the physician already should have told the patient. Here is a palpable reminder of the encounter, designed to help the memory or further instruct family, friends, and acquaintances. This emphasis on patient education is the book's chief attribute.

Dermatological colleagues may not agree with each of the author's explanations or specific treatment regimens. Nonetheless, the successful therapist will endorse, and practice, the philosophy which Dr. Epstein illustrates nicely in his teaching.

Christopher M. Papa, M.D.

Diabetes: A New and Complete Guide to Healthier Living for Parents, Children, and Young Adults Who Have Insulin-Dependent Diabetes

Lee Ducat and Sherry Suib Cohn. New York, NY, Harper & Row, 1983. Pp. 253. ($13.95)

In recent years, individuals suffering from the same disease have banded together for support as well as to trade experiences and helpful hints in coping with their illness. The principal author of this book is a founder of such a group, stimulated to act when her son was diagnosed as an insulin-dependent diabetic. She founded the Juvenile Diabetes Foundation, whose performance in giving emotional support, disseminating information, and funding research has been outstanding.

This book is neither a cold scientific tome nor a manual of diabetes. On the contrary, it is a compilation of information gleaned from the actual patient and families of those affected. It is a parent-to-parent, no-nonsense approach, pulls-no-punches text—it tells it like it is. The prose is not elegant; the language is plain and occasionally crude, but it fills the gap between the doctor's office and the problems of everyday living with diabetes. Starting from the moment of shock at being told the diagnosis, to the later worries about school, camp, sex, marriage, and the fear of complications, it answers questions that plague all families: I've given my four-year old diabetic child his insulin, how do I get him to eat? What is his future? What if he gets sick with a cold or a gastrointestinal disturbance? Are there physical factors as well as emotional factors preventing or interfering with a good marriage? Can my daughter have a baby? What about my other children?

This book is eminently practical and helpful and should be in the hands of any patient or family with insulin-dependent diabetes. To the parent, it will give as much help and comfort as Dr. Spock's books did in helping rear nondiabetic children. To the physician, it will provide a further understanding of what it is to live and cope with this disease.

Samuel E. Einhorn, M.D.

Disorders of the Hip

David M. Gruebel-Lee. Philadelphia, PA, J.B. Lippincott Co., 1983. Pp. 282. ($49.50)

We have come to expect a certain elegance of style and clarity of word in the books we receive from our British colleagues, and Mr. Gruebel-Lee does not disappoint us in this very personal work. With the exception of a four-page section on the subject of the doctor-patient rela-

tionship, contributed by Dr. David Hirsh of the Albert Einstein College of Medicine, which includes mention of the uniquely American problem of malpractice, this is a distinctly British volume.

The author's preface clearly states that it was his intention to interest, challenge, and stimulate his colleagues and residents in training, through his own understanding of hip disease, as gained from a lifetime's work. In this, I feel that he has clearly succeeded.

Each chapter begins with a brief exposition of what we are to learn, and the text generally delivers; sometimes it is made untidy by the seemingly random and sometime unexpected insertions of case histories. (Case 4 is accompanied by a set of x-rays which apparently are those of another patient!) While the quality of reproduction of the radiographic studies is only fair, the many line drawings superbly illustrate the anatomical concepts they are meant to demonstrate. I cannot recall a clearer demonstration of the concept of femoral anteversion and retroversion than is found here.

That very Britishness which makes this volume so readable, does tend to limit its breadth of view. The discussion of total hip arthroplasty, while giving valuable insight into the development of the procedure and paying due homage to the late Sir John Charnley, virtually ignores current concepts and designs commonly used in this country. This book is not to be any orthopedist's basic reference, nor was that the author's intent. Nevertheless, it deserves a place in the home and office, first to be kept at the bedside table, to be savored in its entirety, morsel by morsel, for its many refreshing aspects, and then to gain its rightful place in the library, as the source of history, information, and controversy which its author intended it to be.

Robert A. Goldstone, M.D.

Power and the Profession of Obstetrics

William Ray Arney. Chicago, IL, The University of Chicago Press, 1983. Pp. 290. ($25)

The author, a sociologist from Evergreen State College, has mounted a prodigious effort to explain the genesis, evolution, and present status of obstetric practice in the United States. It is truly a commendable scholarly achievement by a nonphysician who has crammed into less than 300 pages an amazing amount of factual information liberally laced with opinions from a galaxy of medical and nonmedical authors.

Although Mr. Arney's thrust is not particularly antimale, the concept of "power" that appears in his title as well as his text implies a male movement to control yet another facet of a woman's anatomic and social function, particularly his description of the usurpation of the midwives' role. Moreover, his recitation of the events of the past 20 years should have been tempered by two well-known phenomena to which he seems to have paid scant notice: the increasing number of women who have entered the ranks of academic and clinical obstetrics and gynecology, and the increasing number of malpractice suits with higher and higher awards. The public's expectation of perfect babies has been nurtured by the conscientious efforts of modern obstetrics which tries to anticipate and manage every potential pathologic event and, consequently, occasional unsatisfactory results serve as grist for the monster mill of malpractice. Thus, there is no obstetrician today who does not look daily upon himself or herself as a potential defendant before the bar of justice, thereby influencing the perception and practice of obstetrics.

Despite the author's excellent scholarship, thorough research, and articulate literary style, it still is difficult to determine for whom this book should be recommended. Samuel Johnson once commented about a dog who strutted about on his hind legs; it is not a question of how well he does it but rather why is he doing it at all.

Jerome Abrams, M.D.

Drs. Donnelly; Essertier; Frantantuno; Gilbert; Kline; Koraleck; Read; and Stein

Dr. John H. Donnelly

John Henry Donnelly, M.D., died on January 24, 1984. Born in 1910, Dr. Donnelly earned his medical degree at Jefferson Medical College, Pennsylvania, in 1937. A retired member of our Essex County component, Dr. Donnelly was a cardiologist with offices in Newark and East Orange; he was affiliated with St. Mary's Hospital, Orange, and St. Vincent's Hospital, Montclair. Dr. Donnelly was a Diplomate of the American Board of Cardiovascular Disease, a member of the American Medical Association, and a Fellow of the American Heart Association.

Dr. H.C. Essertier

Harland Crandall Essertier, M.D., former chief of The Valley Hospital, Ridgewood, died on January 14, 1984. A family practitioner, Dr. Essertier was born in 1915 and received his medical degree from the University of Pennsylvania School of Medicine in 1940. A member of our Bergen County component and of the American Medical Association, Dr. Essertier also was affiliated with Hackensack Medical Center and Bergen Pines County Hospital, Paramus.

Dr. M.J. Frantantuno

At the age of 73, Michael Joseph Frantantuno, M.D., died on January 24, 1984. In 1935, Dr. Frantantuno graduated from Marquette University Medical School, Wisconsin. A member of our Essex County component, Dr. Frantantuno was the health officer for the city of Newark. During his career he was affiliated with Clara Maass Medical Center, Belleville, and Saint Michael's Medical Center, Newark. He was a member of the American Medical Association.

Dr. Donald K. Gilbert

On January 12, 1984, Donald King Gilbert, M.D., died. Born in 1933, Dr. Gilbert earned his medical degree at the University of Pennsylvania School of Medicine in 1959. During his career as an internist, Dr. Gilbert was affiliated with Saint Barnabas Medical Center, Livingston. He was a member of our Essex County component and a Diplomate of the American Board of Internal Medicine.

Dr. Oram R. Kline

Word has been received of the death of Oram R. Kline, M.D., last year. Dr. Kline, a retired member of our Camden County component, was born in 1891 and received his medical degree from Jefferson Medical College in 1917. During his lengthy career, Dr. Kline was affiliated with Cooper Medical Center, Camden, Underwood-Memorial Hospital, Woodbury, and Burlington County Memorial Hospital, Mount Holly. Dr. Kline was a member of the American Medical Association and a Fellow of the American College of Surgeons.

Dr. Adolph H. Koralek

Adolph Hugo Koralek, M.D., died on December 26, 1983, at the age of 70. Dr. Koralek earned his medical degree at the University of Prague, Czechoslovakia, in 1938. Dr. Koralek was a member of our Essex County component and of the American Medical Association; during his career, Dr. Koralek was affiliated with Clara Maass Medical Center, Belleville, Saint Barnabas Medical Center, Livingston, and Saint James Hospital, Newark. A family practitioner, Dr. Koralek was a consulting physician for U.S. Steel Co., Newark, for 20 years.

Dr. Hilton S. Read

At the grand age of 84, Hilton Shreve Read, M.D., a retired member of our Atlantic County component, died on January 5, 1984. Dr. Read graduated from Jefferson Medical College in 1923 and during his career was affiliated with Atlantic City Medical Center. He was a member of the American Medical Association, a Diplomate of the American Board of Internal Medicine, and a Fellow of the American College of Physicians. Dr. Read retired to Thomasville, Georgia.

Dr. Steven F. Stein

At the untimely age of 42, Steven F. Stein, M.D., died on December 22, 1983, in an automobile accident. Dr. Stein earned his medical degree at Downstate Medical Center, New York, in 1965. A urologist, Dr. Stein was affiliated with Riverview Hospital, Red Bank, Bayshore Community Hospital, Holmdel, and Monmouth Medical Center, Long Branch. Dr. Stein was a member of our Monmouth County component and of the American Medical Association and was a Fellow of the American College of Surgeons. Dr. Stein also was a Diplomate of the American Board of Urology. He practiced privately in Long Branch and Hazlet.

AUTHOR INFORMATION

Style Sheet

The Journal is the official organ of the Medical Society of New Jersey. The goals of* The Journal *are educational and informational. All material published in* The Journal *is copyrighted by MSNJ.

CONTENT

The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports based on unusual clinical experiences; review articles; clinical notes, succinct items on some aspect or new observation or technique of a case experience; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update; and an opinion column. Editorials are prepared by the Editor and by guest contributors on timely and relevant subjects; editorials are the responsibility of the author. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the Editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made in New Jersey.

ASSIGNMENT OF COPYRIGHT

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978), a transmittal letter or a separate statment accompanying material offered to *The Journal* of the Medical Society of New Jersey must contain the following language and must be signed by all authors:

"In consideration of *The Journal* of the Medical Society of New Jersey taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *The Journal*, MSNJ."

SPECIFICATIONS

Submit two **manuscripts** that must be typewritten and double-spaced on 8½" by 11" paper. Statistical methods used in articles should be identified. Acknowledgements will be made only for specific preparation of an essential part of the manuscript.

Authors are asked to seek clarity, accuracy, and originality; attention to details of grammar, spelling, and typing are important.

The **title page** should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

The author should submit a 40-word **abstract** to be used at the beginning of the article.

Tables must be typewritten and double-spaced on separate 8½" by 11" sheets, with a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source; written permission for republication from the original publisher must be submitted. The cost of color photographs must be borne by the author.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

The **summary** of the article should not exceed 250 words; it should contain only essential facts.

References should not exceed 35 citations except in review articles, and should be cited consecutively in the text by numbers in parentheses at the end of the sentence. The reference list should be typewritten and double-spaced on separate 8½" by 11" sheets in the numerical order in which they are first cited in the text. The style of reference is that of *Index Medicus*:

1. Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis.* New York, NY, McGraw-Hill, 1969, pp. 42-48.

PUBLICATION POLICY

Receipt of each manuscript will be acknowledged and a copy delivered to the Editor who refers the paper to one or more members of the Editorial Board. The final decision is reserved for the Editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. Galley proofs will be submitted to the author for correction of typographical errors.

REPRINT ORDERS

Reprints may be ordered after the author is notified that the article has been selected for a specific issue of JMSNJ. A check for the cost of reprints including remake charge if order is received after due date must accompany the order.

COMMUNICATIONS

All communications should be sent to the Editor, *The Journal*, MSNJ, 2 Princess Road, Lawrenceville, NJ 08648.

SEEKING
RADIOLOGY OFFICE PRACTICE

A Board Certified Radiologist with nine years hospital based experience is seeking to buy into or buy out an active private office radiology practice in Northern or Central New Jersey.

Write: Box No. 71 JMSNJ
Two Princess Road
Lawrenceville, NJ 08648

PHYSICIANS

Private health and social research organization is seeking Physicians for a health and nutrition examination survey sponsored by the U.S. Public Health Service. Physicians will conduct physical examinations using government supplied mobile examination centers in selected areas of the New York Metropolitan area.

Candidates MUST be bilingual in Spanish/English, licensed in at least one state and meet EXTENSIVE travel requirements. Doctors must be board eligible or certified in Family Practice, Internal Medicine or Preventive Medicine.

Competitive salaries, per diem and travel allowances. Send resume to: Westat, Inc., Attn: Personnel Dept. PM 84, 1650 Research Blvd., Rockville, MD 20850.

GROUP PRACTICE OPPORTUNITIES

BC/BE Family Practitioners for expanding federally qualified HMO, serving 36,000 members from three delivery sites in Cosmopolitan South Jersey area. Congenial staff of 30 full-time physicians, and 75 to 100 contracting specialists covering all disciplines. Excellent hospital facilities. Medical school affiliation. Choice of pleasant living conditions in suburban, rural, or semi-rural communities. Superior schools. Easy access to Philadelphia (15 minutes), New York City (90 minutes), Jersey Shore (60 minutes), Jersey Pine Barrens (20 minutes) and Pocono Recreation Area (2 hours). Competitive salary and comprehensive benefit package.

Send Curriculum Vitae to Kenneth M. Carroll, M.D., Executive Vice President/Medical Affairs, Health Care Plan of New Jersey, 165 Old Marlton Pike, Medford, New Jersey 08055.

PHYSICIAN

HOUSE PHYSICIAN/ MEDICAL OFFICER

Our progressive acute care JCHH accredited community hospital is seeking an Intensivist, 1 or 2 years training in critical care medicine, post internal medicine residency. Full responsibility for handling all critical care and trauma situations in the hospital. Board Certified or admissibility preferred. This position has a potential for future development of private practices in several sub-specialities. Our well managed hospital is located in a desirable community in southern New Jersey easily commutable to Philadelphia, Atlantic City, Trenton, and Wilmington. We offer a competitive salary and liberal fringe benefits. Send resume to:

James J. Duncan
Vice President for Human Resources

NEWCOMB HOSPITAL
65 S. State St.
Vineland, NJ 08360

an equal opportunity employer

UNIVERSITY PHYSICIANS

STUDENT HEALTH PROGRAM

Responsible for providing primary care to student and dependent population. Requires experience in adolescent and young adult medicine, including athletic medicine, office gynecology and management of emotionally-related medical problems. Strong clinical skills and ability to administer a student health clinical program desirable. Candidate should be Board Certified or eligible in Internal Medicine, Pediatrics or Family Practice Medicine. Position will require some evening and weekend responsibilities including inpatient rounds. Salary and benefits competitive for college health field. The Isabella McCosh Health Center is AAAHC accredited with a staff of six full-time physicians.

EMPLOYEE HEALTH PROGRAM

Responsible for EMPLOYEE HEATH PROGRAM, including supervision of supporting staff, primary care of work-related injuries and illnesses, evaluation of compensation cases, and liaison with University departments. Position also includes some clinical responsibilities in student health care. Candidate should be Board Certified or eligible in Internal Medicine. Experience in employee health care and demonstrated administrative ability required. Experience in adolescent and young adult medicine highly desirable. Some evening and weekend responsibilities including inpatient rounds. Salary and benefits competitive for college health field. The Isabella McCosh Health Center is AAAHC accredited. Facilities include: an ambulatory care service, 21-bed inpatient service, x-ray and laboratory, counseling center, pharmacy services, health education, athletic medicine, physical therapy, and a Department of Occupational Health and Safety.

Forward C.V. and three current references to:

L.A. PYLE, Jr., M.D.
Director, University Health Services
c/o PERSONNEL SERVICES, CLIO HALL-MSN
PRINCETON UNIVERSITY
PRINCETON, NEW JERSEY 08544

PRINCETON UNIVERSITY

An Equal Opportunity/Affirmative Action Employer M/F

Need A Temporary Physician?

CompHealth treats your practice as if it were our own during: vacations, CMEs, recruiting, clinic start-up or other absences.

Want Free Time While You Practice Medicine?

Join CompHealth's Locum Tenens Physician Group.

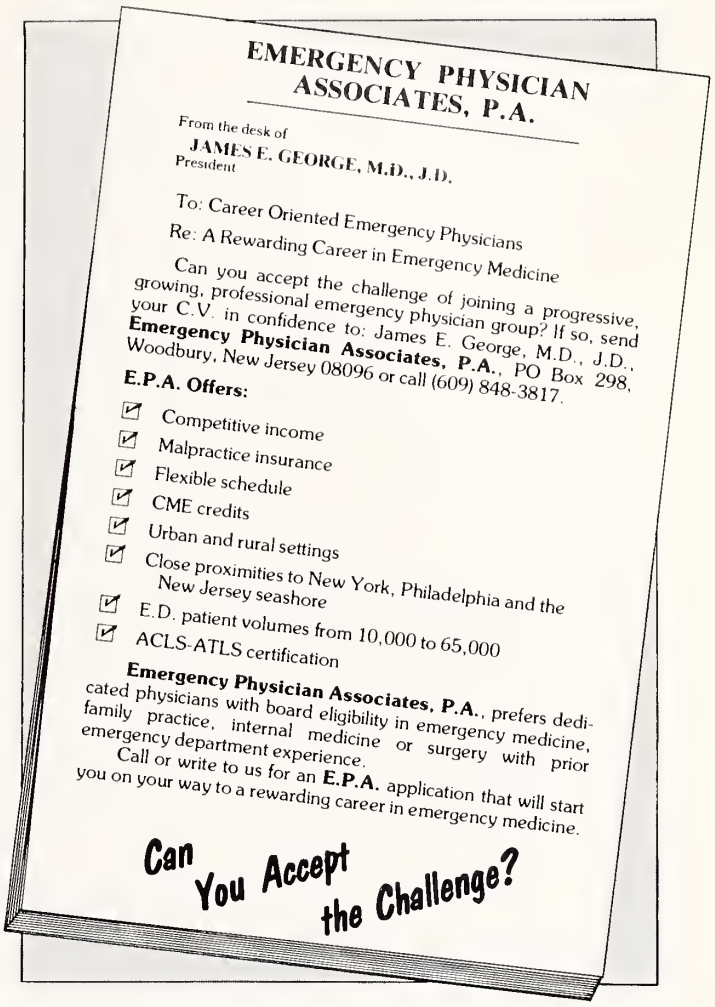
★

For further information about temporary coverage or locum tenens practice opportunities, call:

CompHealth

A Physician Group

WILSON ROSS, Regional Administrator
114 Centennial Avenue
Sewickley, PA 15143
Telephone: 412/741-3310



EMERGENCY PHYSICIAN ASSOCIATES, P.A.

From the desk of
JAMES E. GEORGE, M.D., J.D.
President

To: Career Oriented Emergency Physicians

Re: A Rewarding Career in Emergency Medicine

Can you accept the challenge of joining a progressive, growing, professional emergency physician group? If so, send your C.V. in confidence to: James E. George, M.D., J.D., **Emergency Physician Associates, P.A.**, PO Box 298, Woodbury, New Jersey 08096 or call (609) 848-3817.

E.P.A. Offers:

- ☑ Competitive income
- ☑ Malpractice insurance
- ☑ Flexible schedule
- ☑ CME credits
- ☑ Urban and rural settings
- ☑ Close proximities to New York, Philadelphia and the New Jersey seashore
- ☑ E.D. patient volumes from 10,000 to 65,000
- ☑ ACLS-ATLS certification

Emergency Physician Associates, P.A., prefers dedicated physicians with board eligibility in emergency medicine, family practice, internal medicine or surgery with prior emergency department experience.

Call or write to us for an **E.P.A.** application that will start you on your way to a rewarding career in emergency medicine.

Can You Accept the Challenge?

Wanted: Physicians who prefer medicine to paperwork.

We are looking for dedicated physicians, physicians who want to be, not salesmen, accountants, and lawyers, but physicians. For such physicians, we offer a practice that is practically perfect, where in almost no time you experience a spectrum of cases some physicians do not encounter in a lifetime, where you work without worrying whether the patient can pay or you will be paid, and where you prescribe, not the least care, nor the most defensive care, but the best care.

If that is what you want, join the physicians who have joined the Army. Army Medicine is the perfect setting for the dedicated physician. Army Medicine provides wide-ranging opportunities for the student, the resident, and the practicing physician alike.

Army Medicine offers fully accredited residencies in virtually every specialty. Army residents generally receive higher compensation and greater responsibility than do their civilian counterparts and score higher on specialty examinations.

Army Medicine offers an attractive alternative to civilian practice. As an Army Officer, you receive substantial compensation, extensive annual paid vacation, a remarkable retirement plan, and the freedom to practice without endless insurance forms, malpractice premiums, and cash flow worries.

Army Medicine:

The practice that's practically all medicine.

FOR FURTHER INFORMATION CALL COLLECT:
1LT John J. Schafer, AMEDD Personnel Counselor, USA MEDDAC, Fort Dix, NJ 08640 Phone: (609) 562-4271

An Equal Opportunity Employer

CLASSIFIED ADVERTISEMENTS

DIAGNOSTIC RADIOLOGIST—Board certified, trained in general diagnosis, nuclear medicine, special procedures, C.T. and ultrasound. Available full or part-time; group practice or hospital based; North or Central NJ. Can also provide mobile ultrasound and office consultation. Reply Box No. 63, JMSNJ.

ENDOCRINOLOGIST-INTERNIST—34, Board certified in internal medicine and in endocrinology (1979). Desires partnership or group practice in Northeast NJ, NYC or vicinity. Experience includes major teaching university and private practice. Available immediately. Reply Box No. 74, JMSNJ.

FAMILY PRACTICE RESIDENT—New Jersey born, available July 1984. Interested in joining group practice or existing Family Practice. Write Box No. 72, JMSNJ.

GENERAL PRACTITIONER—Desires industrial, pharmaceutical or similar position. Semi-retired, age 55, 201-545-4339.

GENERAL SURGEON—Board certified, wishes to join another surgeon or a group in area of Monmouth County or adjoining counties. If interested please contact Dr. Hasan 201-972-1584.

INTERNAL MEDICINE—Board eligible, general internist with extensive emergency room experience. Seeking group practice of internal medicine or emergency room position. Northern NJ area. Available July 1984. Please call 212-645-4616, Steven Wolinsky, M.D. Curriculum vitae and references available upon request.

INTERNAL MEDICINE—Seeking small group practice 1½ hours from NYC, CT, NJ. Boston and NYC University hospital trained internist. Boston University MD Cum Laude, 1981. ABIM eligible and available July 1984. Contact Box No. 70, JMSNJ.

OB/GYN—Board certified, 35, experienced. Wants to relocate. Solo, group or partnership. Available immediately. Write Box No. 66, MSNJ.

OPHTHALMOLOGIST—Board eligible, July 1984. Board certified Pediatrics (1982), age 29, desires partnership or group. Available July 1984. Write Box No. 65, JMSNJ.

PHYSICIAN—Retired MD, age 60, seeks part or full time job in South Jersey. Prefer institutional, outpatient or insurance work. Telephone 609-927-7782 or 609-927-1873.

PHYSICIANS—Registered Dietitian available to provide nutritional counseling for your patients at your office or mine. Trenton - Princeton - New Brunswick area. Call 609-737-2160.

PEDIATRICIAN—Middle-age, board certified, planning to sell private practice. Seeks part-time position, Pediatric clinic or office. Prefer Monmouth or Ocean County. Willing to work nights and weekends. Write Box No. 73, JMSNJ.

NEEDED CARDIOLOGIST/INTERNIST Cardiologist needed for multi-specialty Internal Medicine group in the South Jersey area near Atlantic City. Salary with eventual partnership. Excellent benefit package. If interested please send curriculum vitae to Box No. 76, JMSNJ.

NEEDED FAMILY PHYSICIAN—Board eligible, for partnership in one of the largest family practice facilities in New Jersey. Please send resume to Box No. 69, JMSNJ.

NEEDED PEDIATRICIAN—A well established pediatric office in Southern New Jersey seeks a pediatrician-generalist or subspecialist as an Associate. Write Box No. 75, JMSNJ.

NEEDED ASSOCIATE—Board certified Pediatrician seeks board certified/eligible associate to join well established practice. Excellent opportunity, Northern NJ near NYC. Write Box No. 40, JMSNJ.

NEEDED PHYSICIANS—For successful, well-known, walk-in medical office center, Central NJ. Full time and part time, skilled and personable American trained MD's. Send CV to Medemerge, 1005 N. Washington Ave., Greenbrook, NJ 08812.

NEEDED PRIMARY CARE PHYSICIANS Private fee-for-service practice in new, fully equipped suburban offices. All personal supplies and management services provided. This is an excellent opportunity for physicians with a good "bedside" manner interested in developing a lucrative practice and still desiring time for the pursuit of happiness. Reply to Neighborhood Doctor Corporation, 901 Long Beach Blvd., Ship Bottom, NJ 08008.

ALLERGY PRACTICE—Allergist certified or board eligible for Purchase of very desirable Practice, child and adult. Central, NJ. Write Box No. 47, JMSNJ.

RADIOLOGY OFFICE PRACTICE WANTED—Board certified Radiologist with nine years hospital based experience is seeking to buy into or buy out an active private office radiology practice in northern or central NJ. Write Box No. 71, JMSNJ.

EQUIPMENT—For Sale Irex System II M-Mode echocardiogram, mint condition, 2 years old, asking $10,000.00. Will accept terms. Call 201-748-6101.

EQUIPMENT—Pulmonary equipment and office space for lease in Trenton, NJ. Vicinity in Medical Arts Bldg with radiology, internal medicine, laboratory and cardiology. Excellent opportunity. Lease Negotiable. Call Monday—Friday 8-4:00 p.m. 609-883-0500 ext. 30.

EQUIPMENT—For Sale, X-ray, Fisher 300 MS, very little use, reasonable. Call 201-627-2544.

FOR SALE—INTERNIST/CARDIOLOGIST/PRACTICE—Recently retired, moving Autumn 1984 from 1½ acre landscaped property with tennis court. Large home with adjoining 1200 square feet furnished office, ideal for solo or partnership practice. Office available for rental occupancy now. Location 8 miles from Atlantic City and Ocean City, ten minutes drive to two large modern hospitals, also X-ray and laboratory facilities nearby. Write or phone: Peter H. Marvel, MD, FACC, 2216 Shore Road, Northfield, NJ 08225. Home phone 609-641-2442. Exchange 609-641-0132.

FOR SALE MEDICAL PRACTICE—Established, Cardiology & Internal Medicine, Essex County. Office fully equipped, ready to take over. Grossing $250-$300 thousand yearly with room for significant increase. Write Box No. 77, JMSNJ.

FOR SALE OB/GYN PRACTICE—Immediately, Northern Monmouth County near two accredited hospitals in appealing residential community, will introduce. Call 201-264-7763.

FOR SALE PEDIATRICS PRACTICE—Long established practice, ½ block from hospital. Property and equipment. Located in Middlesex County. Will introduce. Write Box No. 64, JMSNJ.

PRACTICE SPECIAL OPPORTUNITY—Large beautiful office, fully furnished and equipped. Excellent location at bus stop and near hospital. Can serve 1 or 2 doctors, other health career personnel or other profession. Available due to physician's death. Patients waiting. Contact Mrs. L. Friedman, 18th and Northampton Sts., Easton, PA 18042. 215-252-6341.

FOR SALE OR RENT—For immediate occupancy, new, modern, energy efficient building, 500 to 2,000 square feet available. 31,000 residents within three mile radius. Close to Philadelphia, Atlantic City. Central Jersey shore area. Internists and specialists needed. Ideal for main/satellite office. Call 201-350-1008.

FOR SALE OFFICE SPACE—Roselle. Modern 2,400 square feet. 6 treatment rooms and 4 consultation rooms, on-site parking. Warinanco Medical Building. Phone 201-687-0102.

CLASSIFIED ADVERTISEMENTS

OFFICE SPACE—Available for rent in fully equipped internist's office in Berkeley Heights. For further information call 201-376-8511, 9-5 pm, Monday-Friday.

FOR RENT—Fully equipped and furnished physician's office just 18 miles west of Atlantic City, NJ. Call 609-965-1600. Write Mrs. Marie Frank, 227 Philadelphia Avenue, Egg Harbor City, NJ 08215.

OFFICE FOR RENT—Professional office, approximately 710 square feet, near Dover General Hospital. Near Routes 80 and 46. Morris County, NJ Telephone 201-366-2557.

OFFICE FOR RENT—Point Pleasant office space available on part-time basis in new professional building. Fully equipped, including x-ray. Reply Box No. 78, JMSNJ.

OFFICE FOR SHARE—Hudson County at two locations, near hospitals and transportation. 201-864-7172.

OFFICE FOR SHARE—Morristown, central location. Near hospital, fully equipped, newly decorated. All utilities included. Ample parking available. Near public transportation. Available immediately. 201-267-2555.

OFFICE FOR RENT OR SHARE—Hazlet-Holmdel area. Spacious, furnished 600-1500 square feet, ample parking, close to hospital. Call 201-264-7763.

FOR RENT/SHARE—Up to 2000 square feet in Red Bank opposite Riverview Hospital, ample parking nearby, elevator, central air, phone 201-747-4127.

OFFICE TO SHARE—Westfield, central location. Near hospital, fully equipped, attractively decorated. All utilities included. Ample parking available. Near public transportation. Available immediately. 201-267-2555.

BOAT FOR SALE—1982, Sea Ray Sedan, fly bridge, head, shower, all extras. 26 foot by 10 ffot. 201-864-7172.

KIAWAH ISLAND—Wild Dunes Beach and Racquet Club. Charleston, SC resorts. Choice 1-4 bedroom villas for rent. In prime locations, including oceanfront. 25% owner discount. Brochure 803-556-6353.

RATE INFORMATION FOR MEMBERS: $5.00 per insertion up to 25 words; 10 cents each additional word. Payable in advance. **WORD COUNT:** Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one word, and "Write Box No. 000, c/o JMSNJ" as six words. **COPY DEADLINE:** Fifth of preceding month.

PROGESTERONE SUPPOSITORIES
25 mg., 50 mg., 100 mg., 200 mg., & 400 mg.
Boric Acid Suppositories 600 mg.

in both Polyethylene Glycol Base and Fatty Base for Vaginal or Rectal Use, are now being compounded at the following Pharmacy

Hidden Lakes Pharmacy

2039 Rt. #27, Somerset, N.J. 08873 201-821-8500
Howard L. Rubenstein, R.Ph.

Specific dosage and ingredient requirements can be tailored to your patients needs. We specialize in compounding prescriptions.

Delivery available to your patients home. Call for details.

TAX PREPARATION AND PLANNING

- Individual, Partnership, Corporate, Business, Estate Services
- Expert Services
- Federal, Any State, Foreign Taxes of any type
- All Year Service
- Audit Representation
- Tax Planning and Reduction
- In Home or In Office Service

H. Michael Zukowski
(201) 945-8443

It's A Major Medical Explosion

The Lakewood, Toms River and Point Pleasant hospitals are all going ahead with major expansion programs . . . Bricktown to build new facility.

Cross River Professional Center
400 to 2,300 Square Feet
¼ Mile South of Kimball Medical Center

- $9 to $11 per square foot
- Graduated rent schedules
- Ownership options available
- Fully landscaped
- Centrally located and 10 minutes to three major hospitals
- Private entrances and all services available
- Equipment leases available

BARRYMOR ENTERPRISES Brokers Protected
1200 River Avenue (Route 9), Lakewood, NJ 08701 • (201) 367-2226

TWO MEDICAL SUITES

Available June 1st—Livingston Avenue (Doctors' Row)—New Brunswick, NJ. Both suites fully carpeted, sink, closets in each room. One suite has X-Ray room with equipment.

For Information Please Call
201-828-2715

CARE FOR YOUR COUNTRY.



As an Army Reserve physician, you can serve your country and community with just a small investment of your time. You will broaden your professional experience by working on interesting medical projects in your community. Army Reserve service is flexible, so it won't interfere with your practice. You'll work and consult with top physicians during monthly Reserve meetings. You'll also attend funded continuing medical education programs. You will all share the bond of being civic-minded physicians who are also commissioned officers. One important benefit of being an officer is the non-contributory retirement annuity you will get when you retire from the Army Reserve. To find out more, simply call the number below.

CALL COLLECT OR USE THE COUPON AT BOTTOM:

215-443-1703/1705

CPT HARRY SIMPSON
AMEDD Procurement Office
31-D N. York Road
Hatboro, PA 19040

NAME: _____ , MD/DO

SPECIALTY: _____

ADDRESS: _____

TELEPHONE: _____

BEST TIME TO CALL: _____ (AM/PM)

THE JOURNAL OF THE MEDICAL SOCIETY OF

NEW JERSEY

MAY 1984



The Library

LIBRARY
U.C. SAN FRANCISCO
MAY 30 1984

BATSTO RIVER, NEW JERSEY

Send this coupon for no-obligation information of the savings under the Medical Society of New Jersey Endorsed Insurance Plans

Check this list against your coverages . . . .

- ☐ $5000 Monthly Guaranteed Convertible Accident and Health
- ☐ $10,000 Monthly Practice Overhead Expense
- ☐ $1,250,000 Term Life Insurance
- ☐ $500 Deductible COMPREHENSIVE MILLION-DOLLAR MAJOR MEDICAL PLAN—No other coverage needed—Issuable to Age 69
- ☐ $15,000 Deductible MILLION-DOLLAR UMBRELLA MAJOR MEDICAL PLAN for holders of Blue Cross and other Major Medical Plans—Issuable to Age 69
- ☐ $100-a-day Hospital Income Policy
- ☐ $200,000 High Limit Accident Plan
- ☐ Keogh and Corporate Plan NOW! $15,000 KEOGH

E. & W. Blanksteen Agency, Inc.

E. & W. Blanksteen
75 Montgomery St.,
Jersey City, N.J. 07302
(201) 333-4340
or (800) 742-2849

Name: _____

Address: _____

_____

Tel. No. _____

Best Time To Call _____

"A MIDLANTIC AUTO LOAN PUTS YOU IN THE DRIVER'S SEAT WITHOUT LEAVING YOUR WALLET ON EMPTY."

"Worried the cost of a new car won't leave ou much cash for gas? Get an auto loan from he Hungry Bankers.

"Our interest rates help you get more mile- ge out of your money.

"And we offer a wide range of repay- nent plans that let you spread out the ost over many months.

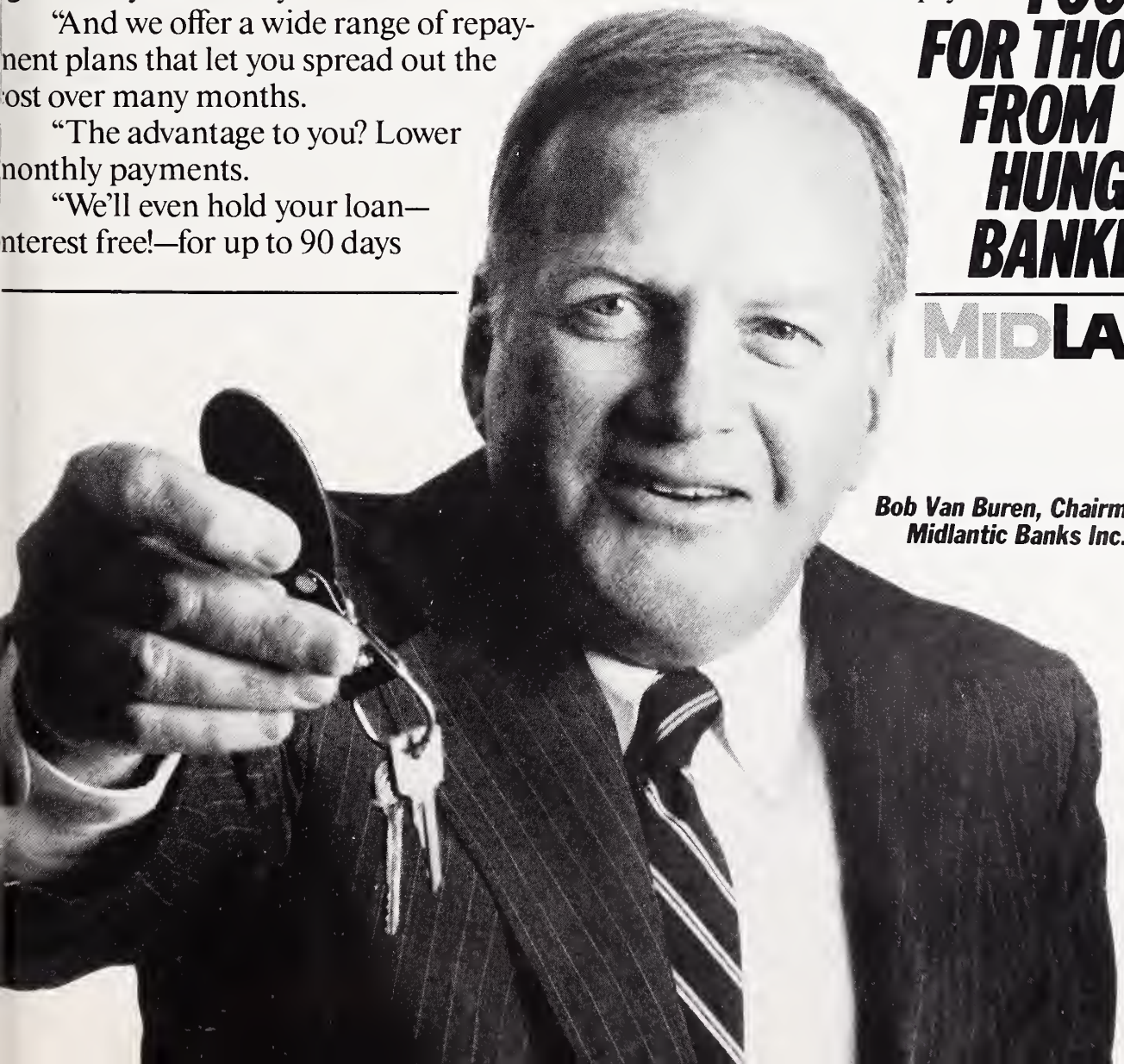
"The advantage to you? Lower nonthly payments.

"We'll even hold your loan— nterest free!—for up to 90 days while you shop around for the best deal.

"To apply, just stop by any of our offices. "We'll put you in the driver's seat without leaving your wallet on empty."

FOOD FOR THOUGHT FROM THE HUNGRY BANKERS

MIDLANTIC



Bob Van Buren, Chairman, Midlantic Banks Inc.

Member FDIC
Equal Opportunity Lender

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

Officers and Trustees

PRESIDENT
Alexander D. Kovacs, M.D. (Union) ..... Scotch Plains
PRESIDENT-ELECT
Frank Y. Watson, M.D. (Essex) ..... Glen Ridge
FIRST VICE-PRESIDENT
Ralph J. Fioretti, M.D. (Bergen) ..... Rochelle Park
SECOND VICE-PRESIDENT
Edward A. Schauer, M.D. (Monmouth) ..... Farmingdale
IMMEDIATE PAST-PRESIDENT
Howard D. Slobodien, M.D. (Middlesex) ..... Metuchen
SECRETARY
Arthur Bernstein, M.D. (Essex) ..... South Orange
TREASURER
Paul J. Hirsch, M.D. (Somerset) ..... Bridgewater

Trustees

Douglas M. Costabile, M.D., *Chairman* (1984) (Union) ..... Murray Hill
Frank Campo, M.D. (1984) (Mercer) ..... Trenton
Harry M. Carnes, M.D. (1985) (Camden) ..... Audubon
Joel S. Cherashore, M.D. (1986) (Essex) ..... Nutley
John J. Crosby, Jr., M.D. (1984) ..... Jersey City
Palma E. Formica, M.D. (1984) (Middlesex) ..... New Brunswick
Harry W. Fullerton, Jr., M.D. (1985) (Salem) ..... Carney's Point
Frank Gingerelli, M.D. (1986) (Bergen) ..... Hackensack
William Greifinger, M.D. (1984) (Essex) ..... Belleville
John P. Kengeter, M.D. (1984) (Ocean) ..... Toms River
Edwin W. Messey, M.D. (1985) (Burlington) ..... Willingboro
Myles C. Morrison, Jr., M.D. (1985) (Morris) ..... Morristown
John J. Pastore, M.D. (1986) (Cumberland) ..... Vineland
Michael R. Ramundo, M.D. (1984) (Passaic) ..... Clifton

Councilors

FIRST DISTRICT
(Essex, Morris, Union, and Warren Counties)
Edward M. Coe, M.D. (1984) ..... Cranford
SECOND DISTRICT
(Bergen, Hudson, Passaic, and Sussex Counties)
Robert A. Weinstein, M.D. (1986) ..... Newton
THIRD DISTRICT
(Hunterdon, Mercer, Middlesex, and Somerset Counties)
Albert F. Moriconi, M.D. (1985) ..... Trenton
FOURTH DISTRICT
(Burlington, Camden, Monmouth, and Ocean Counties)
Frederick W. Durham, M.D. (1984) ..... Haddonfield
FIFTH DISTRICT
(Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties)
Paul H. Steel, M.D. (1986) ..... Atlantic City

AMA Delegates

William J. D'Elia, M.D., *Chairman* (1985) ..... Spring Lake
Alfred A. Alessi, M.D. (1984) ..... Hackensack
Frederick W. Durham, M.D. (1984) ..... Haddonfield
Palma E. Formica, M.D. (1984) ..... New Brunswick
Karl T. Franzoni, M.D. (1984) ..... Trenton
John S. Madara, M.D. (1984) ..... Salem
Henry J. Mineur, M.D. (1984) ..... Cranford
Myles C. Morrison, Jr., M.D. (1985) ..... Morristown
Howard D. Slobodien, M.D. (1985) ..... Metuchen

AMA Trustee

James S. Todd, M.D. (Ridgewood) ..... Bergen

May 1984

Publication Committee

Paul J. Hirsch, M.D., *Chairman*
Dirck L. Brendlinger, M.D.
Frederick B. Cohen, M.D.
A. Olusegun Fayemi, M.D.
Robert M. MacMillan, M.D.
Leon G. Smith, M.D.
La Verne Fioretti

Editor

Arthur Krosnick, M.D.

Managing Editor

Geraldine R. Hutner

Assistant Managing Editor

Dorothy J. Griffith

Advertising Manager

E. Elizabeth Cookson

Executive Director

Vincent A. Maressa

Executive Director Emeritus

Richard I. Nevin

Editorial Board

Jerome Abrams, M.D. (Obstet/Gynecol)
Joseph Alpert, M.D. (Vasc Surg)
Harold Arlen, M.D. (Otolaryngol)
Alfonse Cinotti, M.D. (Ophthalmol)
Robert Dodelson, M.D. (Nephrol)
Wm. A. Dwyer, Jr., M.D. (Surg)
Norman H. Ertel, M.D. (Int Med/Endocrinol)
Daniel P. Greenfield, M.D. (Psychiat)
Christine E. Haycock, M.D. (Sports Med)
Monroe S. Karetzky, M.D. (Pulmon Med)
Avrum L. Katcher, M.D. (Pediatr)
Stanley C. Leonberg, Jr., M.D. (Neurol)
Joel D. Levinson, M.D. (Gastroenterol)
Henry R. Liss, M.D. (Neurosurg)
Geobel A. Marin, M.D. (Int Med/Gastroenterol)
Donald G. McKaba, M.D. (Allergy)
Robby Meijer, M.D. (Plas Surg)
Frank T. Padberg, Jr., M.D. (Surg)
Christopher A. Papa, M.D. (Dermatol)
Norman Riegel, M.D. (Book Review)
Edwin L. Rothfield, M.D. (Cardiol)
Benjamin F. Rush, Jr., M.D. (Surg)
Morris H. Saffron, M.D. (Med His)
Mark M. Singer, M.D. (Int Med/Endocrinol)
Sheldon D. Solomon, M.D. (Rheum)
Lloyd N. Spindell, M.D. (Radiol)
A. Arthur Sugerman, M.D. (Psychiat)
Stephen F. Wang, M.D. (Pediatr)
Edwin S. Wilson, M.D. (Radiol)
Louis S. Zeiger, M.D. (Nucl Med)
Robert B. Zufall, M.D. (Urol)

The Journal of the Medical Society of New Jersey (ISSN-0025-7524) is published monthly (since 1904) except semimonthly in July (13 issues), under direction of the Committee on Publication, by the Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648. Printed in East Stroudsburg, PA, by the Hughes Printing Co. Whole number of issues 962. Member's subscription ($10) is included in Society dues. Rates for nonmembers, $20; outside USA add $7.50 for postage. Single copies, $2. Address communications to *The Journal* MSNJ, Two Princess Road, Lawrenceville, NJ 08648, (609) 896-1766. Second-class postage paid at Trenton, NJ, and additional entry office.

Copyright 1984 by the Medical Society of New Jersey.

Motrin®

ibuprofen, Upjohn

600 mg Tablets



More convenient for your patients.

Upjohn

84 The Upjohn Company

The Upjohn Company • Kalamazoo, Michigan 49001 USA

J-4044 January 1984

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

MAY 1984

FEATURES

359 Membership Newsletter
365 Professional Liability Commentary
371 Editorial

CONTRIBUTIONS

377 Selection of a Medical Office Computer System
J.W. Allen, M.D., River Edge

383 The Psychological Impact of Cancer on Patient and Family
B.A. Singer, Ph.D., Cherry Hill

389 Medical History: Alabama Granny Midwife
L. Holmes, M.P.A., Newark

393 Case Report: Extra-anatomic Bypasses in Aortoenteric Fistulas
C.H. Antinori, M.D., E.H. Kain, M.D., J.A. Kuchler, M.D., V.J. Manuele, M.D., L. Pierucci, Jr., M.D., D.T. Villanueva, M.D., Camden

399 Case Report: Pancreatic Pseudocyst Associated with Valproic Acid Therapy
A.M. Baskies, M.D., Willingboro

404 Case Report: Familial Dysalbuminemic Hyperthyroxinemia—A Variant
M.H. Goldman, M.D., and K. Klinges, M.D., Englewood

406 Commentary: DRG—New Jersey and the Federal System
B.A. Rineberg, M.D., New Brunswick

409 Commentary: DRG—The Executive Director's View
V.A. Maressa, J.D., Lawrenceville

411 Imaging: An Approach to the Diagnosis of Cholecystitis
L.S. Zeiger, M.D., Camden

415 Current Nutrition: Diet and Nutrition in Chronic Renal Failure
N. Lasker, M.D., Newark

421 Opinion: Overcoming Psychic Numbing
B. Grossman, M.D., Trenton

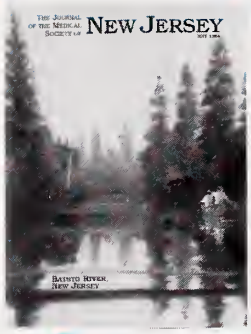
DOCTORS' NOTEBOOK

423 Trustees' Minutes: March 18, 1984
424 UMDNJ Notes, Stanley S. Bergen, Jr., M.D.
424 AMNJ Report, Paul J. Hirsch, M.D.
425 Diagnostic Virology Report
426 Physicians Seeking Location in New Jersey

MSNJ DEPARTMENTS

429 CME Calendar
433 Book Reviews
435 Obituaries
436 Information for Authors

On The Cover: John Bowe, M.D., is a member of our Bergen County component and an artist. The cover, entitled "Batsto River, New Jersey," is just one of Dr. Bowe's many paintings.



It's about time you had a real professional assist you in attaining your personal, practice and retirement investment goals.

Dr. S. Randy Sarantos is that professional.



A doctor with over 20 years of financial experience, who is now a full-time Registered Investment Advisor and financial planner counseling health care professionals, Dr. Sarantos understands the special problems you face in developing your personal estate plan, managing your practice economic goals, planning for your retirement, and investing your pension assets.

Dr. Sarantos is a member of the International Association of Financial Planners and is licensed through Investment, Management & Research, Inc., member National Association of Securities Dealers and Security Investors Protection Corporation and an affiliate of Raymond, James & Associates, Inc., member New York Stock Exchange, in the securities, tax shelter, commodities and insurance investment areas.

For a confidential consultation with Dr. Sarantos, please call or return the coupon below today. He is ready to answer the many diverse financial questions that probably only *another* health sciences professional can effectively answer.

Dr. Sarantos:
Please contact me regarding the following area of interest:

☐ Developing a financial plan
☐ Investment management
☐ Tax shelter planning
☐ Insurance review
☐ Retirement plan review
☐ Practice management review

Name _____

Address _____

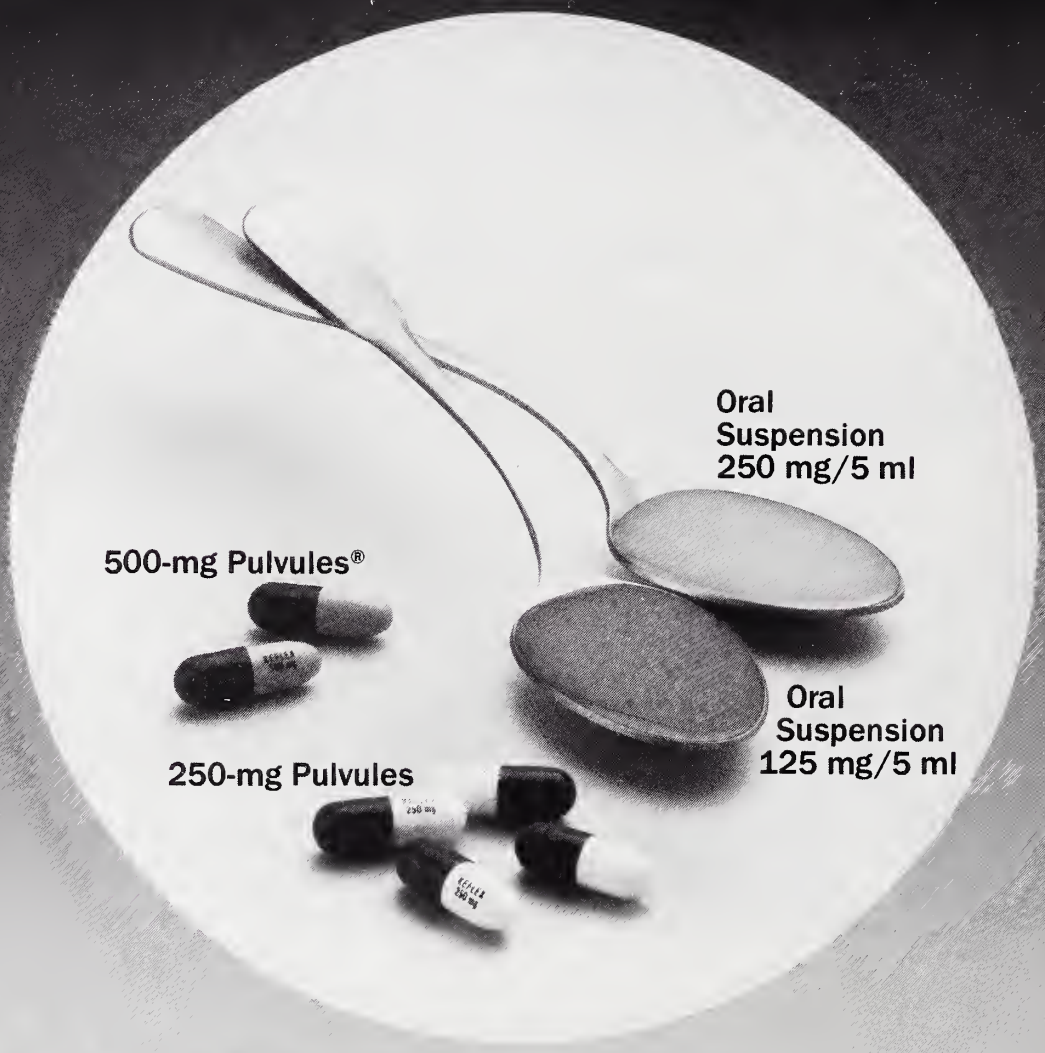
City/State/Zip _____

Office Phone ____/_____ Home Phone ____/_____

Call 800-223-0164
or 201-539-4000 (NJ only)

SARANTOS & LANSING FINANCIAL SERVICES, INC.
240 Cedar Knolls Rd., Cedar Knolls, NJ 07927

Easy To Take



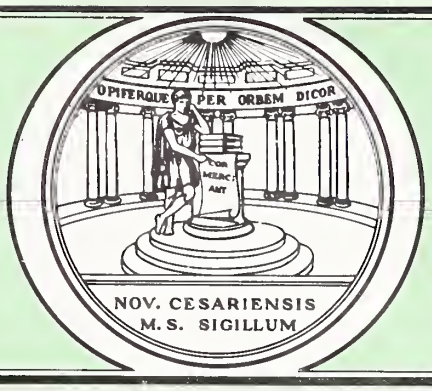
Keflex®
cephalexin

Additional information
available to the profession
on request.

DISTA
420113

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

MEMBERSHIP NEWSLETTER



MSNJ

THE MEDICAL SOCIETY OF NEW JERSEY VOLUME 11

MEDICARE LEGISLATION ADVANCES SIGNIFICANT CHANGE

The Senate Finance Committee recently adopted a $50 billion spending-cut package that contains three specific Medicare proposals of major interest to the profession. These are:

1. Imposition of a three-month freeze on physician Medicare payments.

2. Introduction of a participating physician concept to be triggered in after the three-month freeze. It would permit those accepting assignment 100 percent of the time to obtain Medicare payment increases. No increases would be given to those physicians accepting assignment less than 100 percent of the time. Other administrative incentives also would be applied for those agreeing to be participating physicians.

3. Development of fee schedules for both in- and out-of-hospital clinical laboratories to restrict Medicare payments to 62 percent of the prevailing-fee rate for laboratory services for 3½ years.

The three provisions were adopted by an overwhelming majority in a package vote.

The Senate Finance Committee cited as its justification for creating the participating physician concept the need to stem efforts of some congressional leaders to push for mandatory assignment. The Senate Finance Committee took up a $50 billion revenue package on Tuesday, February 28. The Committee also will be looking at modifications of the DRG rates relative to intensity. The House Ways and Means Committee currently is determining how the full House should deal with the proposed Medicare issues including mandatory assignment.

RULES COMMITTEE ACTION ON MEDICARE

At the start of this month, it appeared that H.R. 4170, the Tax Reform Act, would be considered on the floor of the House at any moment. This bill contained 38 proposals to modify the Medicare program, and also was scheduled to be a vehicle for a committee amendment to be offered on the floor of the House by Chairman Dan Rostenkowski (D-IL). The so-called "Rostenkowski amendment" would have proposed a one-year freeze on physician reimbursement, coupled with a requirement of acceptance of Medicare assignment for all hospital inpatient services provided to Medicare beneficiaries.

H.R. 4170 was considered before the Rules Committee on March 7. The Texas congressional delegation had requested the opportunity to offer an amendment to H.R. 4170 that would allow for a straight one-year freeze on the Medicare prevailing charge without any linkage to mandated assignment. However, before the Rules Committee could act on this request, Congressman Rostenkowski unexpectedly requested that the Medicare cuts and other spending cuts contained in H.R. 4170 be separated from the bill, with only the tax provisions going to the House floor. Subsequently, H.R. 4170, minus the Medicare and other spending cut measures, was cleared for House floor action; the Rostenkowski amendment would not be in order as an amendment to the bill.

The precise future course of the Rostenkowski amendment is uncertain at the moment, but it undoubtedly will arise again attached to another bill or incorporated in a reconciliation measure.

AMA STATEMENT ON VOLUNTARY FEE RESTRAINT

On February 23, the American Medical Association's Board of Trustees unanimously authorized sending a letter to each physician in the United States, urging him or her:

1. To freeze fees for a one-year period, beginning immediately; and

2. To continue to take into account the financial circumstances of each of his or her patients—especially the unemployed, the uninsured, and those under Medicare—and to accept reduced fees when warranted.

Traditionally the AMA, with support from physicians across the country, has been in the forefront of assuring that the profession will do its fair share in providing cost-effective medical care. For example:

- The inaugural address of the AMA president six years ago also asked physicians to decrease the rate of increase in their overall charges.
- In 1978, the AMA endorsed a voluntary program to restrain the rate of increase in physicians' fees, a program that resulted in the physician services com-

ponent of the consumer price index (CPI) registering below the all-items index.

- The Association continually has asked physicians to reduce or waive fees for the unemployed and others who have lost public or private insurance benefits. In response many local medical societies have set up programs to serve the temporarily unemployed.
- Several state medical associations recently have asked their members voluntarily to freeze their fees.

PREFERRED PROVIDER ORGANIZATIONS (PPOs)*

The decision to join or organize a PPO is not an easy one for physicians. If the decision is whether or not to participate in a PPO or other selective contracting arrangement, then the physician needs to evaluate carefully the contracting entity, the contract itself, and the implications that this new way of doing business may have for his medical practice and his relationship with patients. The physician who is deciding whether or not to organize a PPO must, in addition to the above concerns, consider the need for and feasibility of a PPO in his or her community. Before any organizational steps are taken, it is imperative that the physician or group of physicians who are laying the potential groundwork become very well informed about PPOs and their advantages and disadvantages. The more detailed operational knowledge of PPOs physicians possess, the better they can present an accurate picture to their colleagues.

Physicians are interested in organizing or signing a contract with a PPO for many reasons. The concept has both advantages and disadvantages, however, and there are some reasons for physicians to avoid affiliating with a PPO.

As earlier discussed, some advantages enjoyed by physicians in these types of arrangements include a potentially larger patient base, the lack of significant financial risk (in most cases), and the opportunity to participate and still maintain a fee-for-service office-based practice. However, physicians should recognize that there may be no assurance of an increased number of patients unless the PPO provides for a patient lock-in.

Disadvantages which can occur with participation in a PPO include discounted fees (if, for example, the PPO does not deliver the expected increase in volume to offset the discount, the physician will lose money overall), and the negative effects of certain contract provisions offered by some PPOs. Again, as earlier discussed, the physician must make certain he has a clear understanding of all terms and obligations in the contract before signing it. It is advisable to use legal counsel for this purpose. Contract clauses which serve to increase a physician's liability for malpractice or to limit unreasonably the scope of a physician's practice or professional judgment should be avoided.

The organization of a PPO is usually a response to the increased competitiveness of the medical care marketplace. Many proponents see these organizations as an effective means of combating the competitive pressures of other alternative delivery systems or an increased supply of physicians in an area.

A disadvantage for a physician involved in a PPO can be the loss of control over some of the decision making in medical care delivery (and, therefore, over the patient's welfare) to hospital administrators, third parties, or insurers through the administration of the contracting process. Many physicians believe, however, that this problem is not inherent in selective contracting, but rather that it is a function of who controls the contracting process (usually the PPO sponsor or developer). Consequently, many physicians are eager to maintain a leadership role in the design of the PPO and its fee schedule, procedures, and contracts, rather than surrender that control to insurers, hospital administrators, and third parties. The current legal climate regarding the establishment by physicians of physician fee schedules or agreements, however, is inhospitable. As earlier discussed, physician sponsorship or organization of a PPO best may be accomplished through the establishment of a true joint venture in order to avoid allegations of price-fixing. However, characteristic of a joint venture is the ability to offer some new previously unavailable service as a result of the joint venture, or the joint risk of capital investment.

For both physicians contemplating participation in an PPO and physicians interested in organizing a PPO, the initial step must be to learn as much about the topic as possible. Several helpful, substantial articles have appeared in magazines and journals within recent months. Some are case studies of individual plans. There also are detailed manuals on the subject of selective contracting which are available. These manuals provide a great deal of technical information on the issues involved in selective contracting and give detailed advice on the steps involved in putting such an organization together; however, they have been compiled by groups in California and are therefore particularly relevant to the legal and regulatory climate in California at the moment. They also have a tendency to be very hospital-oriented.

Physicians also will find it helpful at this stage to talk to people who have been involved in this process. Conferences and workshops on the topic are given periodically by various groups and provide a good forum to acquire a working knowledge of the topic, exchange ideas, and meet people who have been involved in these organizations.

Another productive way to learn how a PPO functions is to visit some operating plans. Most physicians and administrators are generous about sharing their expertise; however, it helps to focus the discussion if the visitor has done some background research and comes prepared with a list of questions.

During this information-gathering period, the number of people learning about PPOs should increase. The first discussions probably will involve only a few physicians. It is important that knowledge based on accurate information be shared by an ever-widening circle of peers. Before any concrete steps are taken to begin a feasibility study, to hire consultants, or to seek funding, the physician organizers should be sure to have informal talks with physician leaders in various segments of the medical community.

These early conversations should be small and infor-

*Reprinted with permission from *A Physician's Guide to Preferred Provider Organizations*, American Medical Association, 1983.

nal to facilitate an exchange of ideas and information. Later, when a basic foundation of information and cooperation has been laid, a larger meeting is advisable, with experienced PPO administrators and physicians invited to address the group. If adequate preparation has been made, through small, informational meetings, attendance at the community-wide meeting should be larger, better informed, and more receptive.

If the community, having learned about the concept of a PPO, is either uninterested or hostile, the organizing group should recognize the difficulties of going on with the project. If, on the other hand, there is a sufficient number of physicians in the community interested in pursuing selective contracting as a part of their practice, then the organizers should consider undertaking a formal analysis of the feasibility and marketplace acceptance of the establishment of a PPO in their community.

A PPO's early educational efforts are appropriately focused on physicians and hospitals. However, at some later point in the process of gathering information, it is important to apply similar communication and educational efforts to the nonphysician community. The PPO developers will need to communicate with representatives from industry and unions, insurance carriers, and other health organizaitons. The timing of this stage of activity will differ from one situation to another. Ideally, it will take place when physician leaders have acquired sufficient knowledge of PPOs to have a fairly clear agenda for how they will proceed into a feasibility study. However, it should not be delayed too long, because many nonphysician leaders are both interested in and knowledgeable about the subject of health care financing and delivery systems. They can contribute significantly during the early decision and planning stages. Later, business expertise and ability to assist with marketing will make industry and labor representatives valuable members of an operational plan's governing board.

Business community acceptance and cooperation is important to the success of a PPO. The response and level of interest in the business community should be assessed and a decision made regarding the existence of enough potential support to ensure access to large numbers of the area's employees. If support is lacking or there is very little interest, again the physician organizers should recognize the difficulties inherent in continuing with the project.

If sufficient support and interest exist for the concept of a PPO to appear viable, then the next step for the PPO developers is a careful market analysis, including the development of a marketing plan, and to begin to develop the organizational policies and procedures which will govern the activities of the PPO. The physician developers should be aware that even while the development of policies and procedures is occurring, the market analysis may turn up reasons why the PPO may be unsuccessful. When and if such issues do surface during the planning process, the developers should be prepared to consider seriously whether they represent an insurmountable obstacle that will in all likelihood jeopardize the success and survival of the PPO, or whether they can be dealt with or accommodated as the organization develops.

During this stage of the planning process, many questions of a highly complex and technical nature will need to be answered. Specialists or consultants may need to be brought into the project on a short-term basis for such tasks as determining the amount of the premium, setting up an adequate management information and data system, and researching all the legal requirements. There is no substitute for an expert's advice on some of these issues, particularly in the legal and actuarial fields.

Developing a PPO is a difficult and challenging task, but not an impossible one. There is a growing cadre of PPO administrators and physicians who have made the difficult decisions, corrected their mistakes or miscalculations, and hammered out what they believe to be viable programs. Their experiences will be invaluable to the potential developers of a new PPO. Every opportunity should be taken to learn from them through reading, conferences, and visits to their plans.

During the course of the PPO's development, although it may appear incongruous, it is not unusual to be working toward two different objectives simultaneously: deciding whether a PPO should be formed and planning its formation. In the momentum that gathers around the planning of a new organization, it is imperative that the basic questions not go unasked. Honest answers will indicate the likelihood of the plan's ability to succeed. Is there a well defined need for a PPO solution to the problem, as opposed to another alternative solution such as an HMO? Is there enough commitment on the part of physicians in the community? Are there enough employers who are sufficiently committed to the concept not only to make the PPO option available but to provide enough information so that employees can make an informed choice? Are there enough people who, when offered the option of the PPO, will find it accessible and economically attractive enough to choose?

In the construction of the new organization, careful policy decisions must be made about its structure and composition. Will there be one corporate entity, or two? Will it be a joint venture arrangement? Who will serve on the governing board? What will be the criteria for physician participation? For hospital participation? What payment mechanisms will be worked out? Will the physicians share any economic risk? What procedures will be used for reviewing utilization and quality? There may not be easy consensus on these difficult questions. However, taking the path of least resistance during the planning stages can prove troublesome later, when the operating plan is trying to keep all parts of its budget under control and trying to avoid allegations of anticompetitive behavior.

It is usually helpful to seek the counsel of physicians in other communities who have gone through the same experiences. Their detachment from local issues can lend objectivity when opinions or even personalities begin to conflict. And, of course, competent experienced staff and consultants can aid tremendously in defining the options that are available and recommending what they believe is the best course of action.

In the final analysis, though, the ultimate decision-making responsiblity lies with those who are developing and designing the plan for their own community.

Remaining actively involved in the planning process over a span of many months can be a demanding and tiring experience. It can also be a rewarding one, if the ultimate result is an organization about which physicians can feel satisfied and confident.

SENATE FINANCE COMMITTEE ACTIONS

The Senate Finance Committee has held a number of meetings since February 23 to consider a series of deficit reduction options. None of the options under consideration has been introduced in bill form, and they are subject to modifications. In the course of these meetings, the following recommendations on spending reductions that relate to the Medicare and Medicaid programs have been developed:

Participating Physicians—Physicians' prevailing fees would be frozen for at least three months beginning in April 1984 and the freeze would continue for an additional two years for those physicians unwilling to agree to accept assignment for all services provided to all of their Medicare patients for the following fee screen years. Incentives also would be developed to encourage physicians to accept assignment on all claims. These include publicity of their status as "participating physicians," electronic claims processing for beneficiaries with Medigap coverage, and simplified billing/payment arrangements. Physicians who do not elect to accept assignment for all of their Medicare patients will continue to have the option of assigning claims on a claim-by-claim basis.

Fee Schedule for Clinical Laboratory Services—A fee schedule would be established for clinical laboratory services where payments would be reduced to 62 percent of the prevailing charge levels for all laboratory services payable under Part B. The fee schedule would be in place for 3½ years, until October 1987.

Increase in Part B Premium—The Part B premium would be increased from 1985 to 1990 so that the premium would equal 35 percent of the cost of the Part B program by 1990.

Date of Initial Eligibility for Medicare Entitlement—Eligibility for both Parts A and B of Medicare would be delayed to the first day of the month following the month of an individual's 65th birthday. (Eligibility now occurs on the first day of the month in which an individual attains age 65.)

Working Aged—Where a nonworking spouse is aged 65 to 69 and the working spouse is not yet 65 years of age, the nonworking spouse would have the option of electing primary coverage under the employer group health plan. (Under current law, both the employed individual and spouse must be between the ages of 65 and 69 to create a situation where Medicare could be secondary payor.)

Limiting Increases in Hospital Reimbursement—The rate of increase in hospital reimbursement would be limited for fiscal years 1985 and 1986 to just the hospital market basket. (Under current law, rates will be allowed to increase at the rate of market basket plus 1 percent.)

Reduction in Medicaid Payments—Federal reductions in matching payments for states would continue for an additional three years. The reduction would be at 3 percent for fiscal years 1985, 1986, and 1987. Existing offsets whereby states may qualify to ear back part of all of the reductions would remain i place.

Medicaid Assigment of Rights—States would be re quired to have all Medicaid applicants assign to th state their rights to any third-party recovery for healt care costs. (Current law gives states the option to re quire Medicaid applicants to assign these rights to th state.)

GLUTETHIMIDE RESCHEDULED

Glutethimide, the nonbarbiturate sedative has bee rescheduled in the New Jersey Controlled Dangerou Substances regulations from Schedule III to Schedul II effective February 21, 1984. A final notice of adoptio appeared in the *New Jersey Register*. This drug prod uct is prescribed under the generic name o glutethimide as well as the brand name Doriden®, USV

As a Schedule II drug, the following restriction apply:

1. Only a written prescription may be used t prescribe glutethimide.
2. The prescription is nonrefillable.
3. A prescription for glutethimide may not be writ ten for a quantity greater than a 30 day supply or a 120 dosage unit whichever is the lesser amount.
4. Records of purchase of glutethimide must be kep separate from all other records.
5. Prescriptions for glutethimide must be kept on a separate file.

Since this is a change under New Jersey's code only the need for a federal triplicate order form (DEA-222 is not required.

For additional information on this change, cal 609-984-1308.

NJ AUTO INSURANCE FREEDOM OF CHOICE AND COST CONTAINMENT ACT OF 1984

Assembly Bill #3981, known as the New Jersey Auto mobile Insurance Freedom of Choice and Cost Con tainment Act of 1984, was passed by the State Senat on October 3, 1983, and signed by the Governor th next day.

Section 13 of the legislation requires every auto mobile insurer to offer, on an optional basis, medica expense benefit deductibles in amounts of $500 $1,000, and $2,500 for any one accident for any on person with respect to personal injury protection cov erage, provided in accordance with the law. If an indi vidual elects one of these deductibles a reduction of 1 percent to 40 percent of the cost for personal injur protection, or about $30 a year on the average, will b realized. The deductible selected will be applied before medical expenses are compensable under the insured's automobile policy.

If the insured injured person has other hospi tal/medical coverage, such as offered by our Programs medical expenses used to satisfy the automobile in surance deductible may be submitted to that medica care insurance plan for consideration. The law does not require medical care insurance plans to reimburse fully for the amount of expenses used to satisfy the automobile insurance deductible; those expenses would be subject to the other medical care insurance

olan's policy provisions as to deductibles, copayment, neligible expenses, and maximum benefit.

The Committee on Medical Defense and Insurance wishes to caution the Society's membership that the election of one of these deductibles and the resulting small savings in the cost of automobile insurance may not be worth the added risk of having to pay any or all of the expenses used to satisfy the deductible for persons insured under his or her policy.

AMENDMENT TO SPECIALIST RULE

The Division of Medical Assistance and Health Services of the state of New Jersey's Department of Human Services has proposed a rule which will delete the requirement that in order to be paid as a specialist (by Medicaid) a physician must limit his/her practice to 90 percent of their specialty.

The proposed new rule will allow physicians who qualify as specialists to be reimbursed accordingly. However, physicians must be classified as specialists by the Prudential Insurance Company, the fiscal agent who is responsible for processing physician claims for payment.

Note: No action is required if the physician already is classified as a specialist by the Medicaid program.

The full text of the proposed rule will appear in a subsequent issue of the *New Jersey Register.*

FINAL PROSPECTIVE PAYMENT SYSTEM REGULATIONS

While Health Care Financing Administration regulations on the prospective pricing under Medicare are in constant fluctuation, several significant actions have been taken. These are listed below. Please bear in mind that they refer to federal Medicare and not to the New Jersey DRG Program.

Outlier Funding. HCFA has eliminated the hospital specific portion from outlier funding. Consequently, payments for outliers will become smaller while payments for nonoutlier cases will be increased.

Excluded Hospitals. Alcohol/drug treatment hospitals and units are excluded from federal DRGs until October 1985.

Charges to Beneficiaries. Hospitals may bill for services to patients who elect to remain in the hospital for more than two days past the date the patient is notified that acute care no longer is necessary.

Physician Attestation. A physician must, proximate to discharge, attest in writing to the principal diagnosis, the secondary diagnosis, and the names of the procedures performed. Intentional misrepresentation, concealment, or falsification may be punishable by imprisonment, fine, or civil penalty.

SPORTS MEDICINE AND THE HANDICAPPED

On May 25, 1984, a special symposium entitled, "Sports Medicine and the Handicapped," will be held at the Meadowlands Sports Complex. This day-long event is sponsored by the New Jersey Orthopaedic Society in affiliation with the New Jersey Special Olympics, UMDNJ-New Jersey Medical School, United Children's Hospital, and United Children's Hospital Orthopedic Center. The coordinator and moderator is Max M. Novich, M.D. For further information, please contact the New Jersey Orthopaedic Society.

STEPHEN WICKES PRIZE

The Medical History Society of New Jersey is pleased to announce the establishment of the Stephen Wickes Prize in the History of Medicine. This annual award of $100 is named for Stephen Wickes, the first medical historian in New Jersey. Any currently enrolled undergraduate, graduate, or professional student is eligible to submit an original essay on a historical subject in medical or allied fields. The topic may treat the historical aspects of a current problem, or it may deal with a specific subject in a defined period of the past.

The Committee particularly is interested in topics related to the history of medicine or allied fields in New Jersey. Essays should not exceed 7,000 words and should be submitted by August 1, 1984, to: Chairman, The Stephen Wickes Prize in the History of Medicine, Medical History Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648.

No awards will be made if entries submitted are deemed to be without sufficient merit. The essay selected as the winner by the Committee will be submitted for consideration toward publication in *The Journal* of the Medical Society of New Jersey.

MEDICAL HISTORY SOCIETY OF NEW JERSEY MEETING

The Medical History Society of New Jersey, in affiliation with the Academy of Medicine of New Jersey, will meet at the Medical Society of New Jersey's headquarters in Lawrenceville on Wednesday, May 9. Lester S. King, M.D., well-known historian of medicine, will deliver the annual Morris H. Saffron Lecture, "When Did Medicine Become Scientific?" A pathologist by training, Dr. King long has been interested in the history of the profession.

HEALTH CARE COSTS

A pamphlet prepared by the Office of Public Affairs and Medical Education, MSNJ, now is available for distribution. The brochure is a patient education tool that discusses the high cost of health care and what physicians in New Jersey are doing to control the problem.

A recent national survey showed that one of the greatest concerns of all physicians is high health care costs. The national health care dollar is spent in the following manner: 41 percent for hospital care, 21 percent for personal health care, 19 percent for physicians' services, 11 percent for other health spending, and 8 percent for nursing home care.

You can order this informative pamphlet for office distribution by calling the Public Affairs Office, MSNJ, at 609-896-1766.

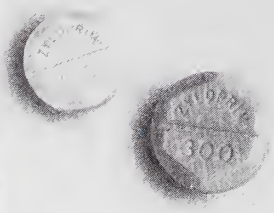
FINI

The highest thing in leadership is credibility.



Only Burroughs Wellcome Co. gives you

ZYLOPRIM®
(allopurinol)



and a whole lot more!

Full support for you, the physician:

- Continuing medical education materials
- On-going clinical studies
- Physician consultation readily available for your questions concerning Zyloprim
- A choice of 100 mg and 300 mg scored tablets

Full support for your patients:

- Patient starter/conversion kits for easy titration of initial dosage
- Patient education pamphlets to encourage compliance
- Burroughs Wellcome Co. quality and economy

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Awards, Advertising, and Professional Coverage

Attorney's Contingency Fee Increased; Fewer Suits in England; Media Advertising; Medicolegal Seminar; Coverage for California Hospitals; Aetna Insurance

The New Jersey Supreme Court has permitted attorneys to increase their contingency fees beginning January 16, 1984. A contingency fee, which is based on the amount of an award in a civil action, is an agreement between the client and the attorney on the fee the attorney will receive for his services. The new contingency fee limits are: 33⅓ percent of the first $250,000; 25 percent of the next $250,000; and 20 percent of the next $500,000. (On a $500,000 award, the fee would be $145,825.) The previous contingency fee limits were: 50 percent of the first $1,000; 40 percent of the next $2,000; 33⅓ percent of the next $47,000; 25 percent of the next $50,000; 20 percent of the next $150,000; and 10 percent of any amount over $250,000. (On a $500,000 award, the fee was $159,451.)

Under Court rules, all contingency agreements in New Jersey must be in writing prior to the start of the case. If the client is an infant or incompetent at the time the contingency fee is made, the fee in settlement, without trial, cannot exceed 25 percent.

The Supreme Court also established a new rule for payment in the event the plaintiff receives funds on an installment basis, otherwise known as a structured settlement. The new ruling calls for contingency fees to be based upon any cash payment made at settlement plus the actual cost to the party making the settlement of the structured settlement. Prior to this new ruling, the contingency fee was based on the total of the structured settlement. New Jersey is one of six states in the nation that limit contingency fees.

WHY ENGLAND HAS FEWER MALPRACTICE SUITS

The annual premium charged in 1982 by the Medical Defense Union, the largest and oldest of Britain's three malpractice insurers, was approximately $250. In the 25 years from 1947 to 1972, only 2,809 malpractice claims were brought, compared to the United States which closed 1½ times as many claims for 1976 alone.

This information, along with reasons why England has fewer malpractice claims, was part of an article on the British health care system which appeared in the January 5, 1984, issue of the *New England Journal of Medicine*.

The authors of the article, William Schwartz, M.D., and Henry Aaron, M.D., contend that among the many impediments to plaintiffs bringing malpractice suits, is the initial cost to the plaintiff. The plaintiff must pay his lawyer a predetermined fee to initiate a suit rather than arrange a contingency fee. Should he lose, the plaintiff also must pay the defendant's costs—typically as of 1971 in the range of $7,500 to $25,000. The Legal Aid scheme entitles indigent plaintiffs to sue at government expense, but few qualify because "indigency" requires disposable income to be less than roughly $3,500 per year.

ATTORNEYS PERMITTED TO ADVERTISE

For the first time, lawyers will be allowed to solicit customers via the electronic media, but do not expect to hear any catchy jingles. The New Jersey Supreme Court recently ruled that lawyers may advertise on radio and television as long as the ads are tasteful and do not misrepresent any facts.

The ruling prohibits the use of "drawings, animations, dramatizations, music, or lyrics" as well as any comments on win-loss records or influence with the courts.

Another major change in the rule that will permit lawyers to advertise on radio and television is a section that will permit out-of-state firms the right to solicit business as long as "the name of an attorney licensed to practice here clearly is set forth in all communications" and that the attorney be responsible for the New Jersey office's operations.

Previously, the out-of-state firm of Jacoby and Meyers was ruled ineligible to advertise or solicit business here because neither of those attorneys was licensed to practice law in the state. (*The Trentonian*, Friday, January 20, 1984)

MEDICOLEGAL SEMINAR

The Medical Society of New Jersey's Department of Professional Liability Control, in conjunction with the Medical Inter-Insurance Exchange of New Jersey, is planning its fifth annual medicolegal seminar for Wednesday, September 12, 1984. Details of this seminar will be mailed to members in early August.

*This item from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse who are, respectively, Director of the Department and Director of Special Projects.

CALIFORNIA HOSPITALS REQUIRE MD COVERAGE

More California hospitals are requiring physicians to carry professional liability insurance as a condition of maintaining staff privileges. A recent survey conducted by the California Hospital Association found that half of the hospitals in the state require such coverage and another 22 percent are considering imposing such a requirement.

This information reflects about a 17 percent increase in hospitals with such a stipulation. A survey conducted by the California Medical Association's Task Force on Professional Liability of all 505 hospitals in the state in late 1981 and early 1982 showed that of the 77 percent who responded, only 32.8 percent required proof of coverage to retain medical staff privileges. Fifty-nine other hospitals said they were considering doing so. At that time, of 221 hospitals who said they do not require coverage, 47 said they never had considered it and 115 had considered but rejected the idea.

A California appeals court ruling handed down June 28, 1983, may have given impetus to the increase in hospitals requiring insurance coverage. In Wilkinson *v* Madera Community Hospital (Civ. 6109), the court not only recognized the right of a hospital to require its physicians to carry malpractice insurance, but to specify further the type of insurance and the nature of the carrier with whom the insurance was placed. The court even went further, indicating that the insurance requirement was a move in the best interests of hospitals, physicians, and patients.

In Wilkinson, a physician went to court to contest a hospital board of trustees' resolution requiring all medical staff members to maintain malpractice insurance with a "recognized insurance company in a minimum amount of $500,000 per occurrence." The case went up on appeal. The plaintiff, whose insurance was placed with an offshore carrier, argued that the insurance requirement and the specifications were unconstitutional on a variety of grounds, among them denial of due process and violation of the equal protection clause. The court rejected each argument, upholding the validity of the insurance requirement, and saying: "In light of the increasing number and amount of personal injury verdicts against doctors and hospitals, it is highly germane to consider a hospital's interest in having its staff doctors insured in an adequate amount and by a reliable carrier. Such coverage protects the vital financial integrity of a hospital. It provides an assured fund to pay a judgment where the doctor is held personally liable. If by reason of the relationship between doctor and a hospital, the hospital is held jointly liable with the primarily responsible doctor, the hospital would have the right of indemnification against the doctor and the doctor's carrier. Thus, the existence of malpractice insurance covering staff doctors would likely reduce the insurance premium on the hospital's liability coverage. Lastly, the existence of such coverage protects hospital patients."

In a memo to California hospitals, Musick, Peeler, and Garrett, California Hospital Association's legal counsel, pointed out that the decision was not fina and that there was a possibility that there could be a petition for rehearing or for a hearing before the Cali fornia Supreme Court.

Even so, the impact of the appeals court ruling is reflected in the recent California Hospital Association survey which revealed that about 72 percent of al California hospitals either already require proof of cov erage from medical staff members or are considering such a requirement. More than half of the hospitals now requiring coverage say that the carrier must b recognized by the state department of insurance, bu only 15 percent specify whether the insurance mus be a particular type—claims made or occurrence About 80 percent require a minimum amount of cov erage with the greatest majority (43 percent) requirin limits of $500,000/$1 million. Another 33 percen specify coverage of $1/$3 million and 21 percent re quire $500,000 or less.

"Nearly 60 percent of the nonprofit hospitals re plying to the survey require coverage, while just unde 40 percent of the investor-owned hospitals do," sai the California Hospital Association. *(Medical Liabilit Monitor*, Vol. 8, No. 12, December 24, 1983)

AETNA LIFE & CASULTY "NO LONGER A MAJOR FACTOR" IN MALPRACTICE MARKETPLACE

Aetna, once the dominant carrier in eight states an doing business in many others, is pulling out of th malpractice market. Aetna spokesman, Matthew M Sheridan, says the company is trying to withdraw from the "unprofitable" line very gradually by notifying the insured that his or her policy will not be renewed.

"We are no longer a major factor in medical malprac tice and the areas we still are active in represent only a small percentage of the total market," said Mr Sheridan. Aetna says it still is active in about ten states, but the giant insurer will not specify which markets those are. Sheridan also declined to say how many physicians and surgeons still are covered by Aetna.

The reasons for Aetna's withdrawal are varied, bu there is reason to believe the insurer, one of the na tion's largest, could not compete with the rise in self insurance and medical and hospital associations pool ing resources to underwrite their own profession plans. Aetna says it could not keep pace with the larg medical malpractice settlements even with increasin its rates. The company would not confirm or den recent reports that it is abandoning the states of Mis souri, Maine, Kentucky, and Wisconsin, but the retrea is in the works, according to sources.

The Iowa Medical Society, for one, hopes that Aetn is not getting out of its state. The Society has had sponsored program with the insurer since 1977. Abou 1,250 physicians are enrolled in the plan. The in surance company has asked the Iowa insurance com missioner to approve a 32.5 percent rate increase fo February 1, 1984, but so far, no action has taken plac on that request. *(Medical Liability Monitor*, Vol. 9, N 1, January 30, 1984)

Find your doctor is the headline in what has to be one of the largest posters ever produced—three feet by five.

This poster is in fact a directory of the approximately 10,000 Participating P.A.C.E. Physicians and Providers.

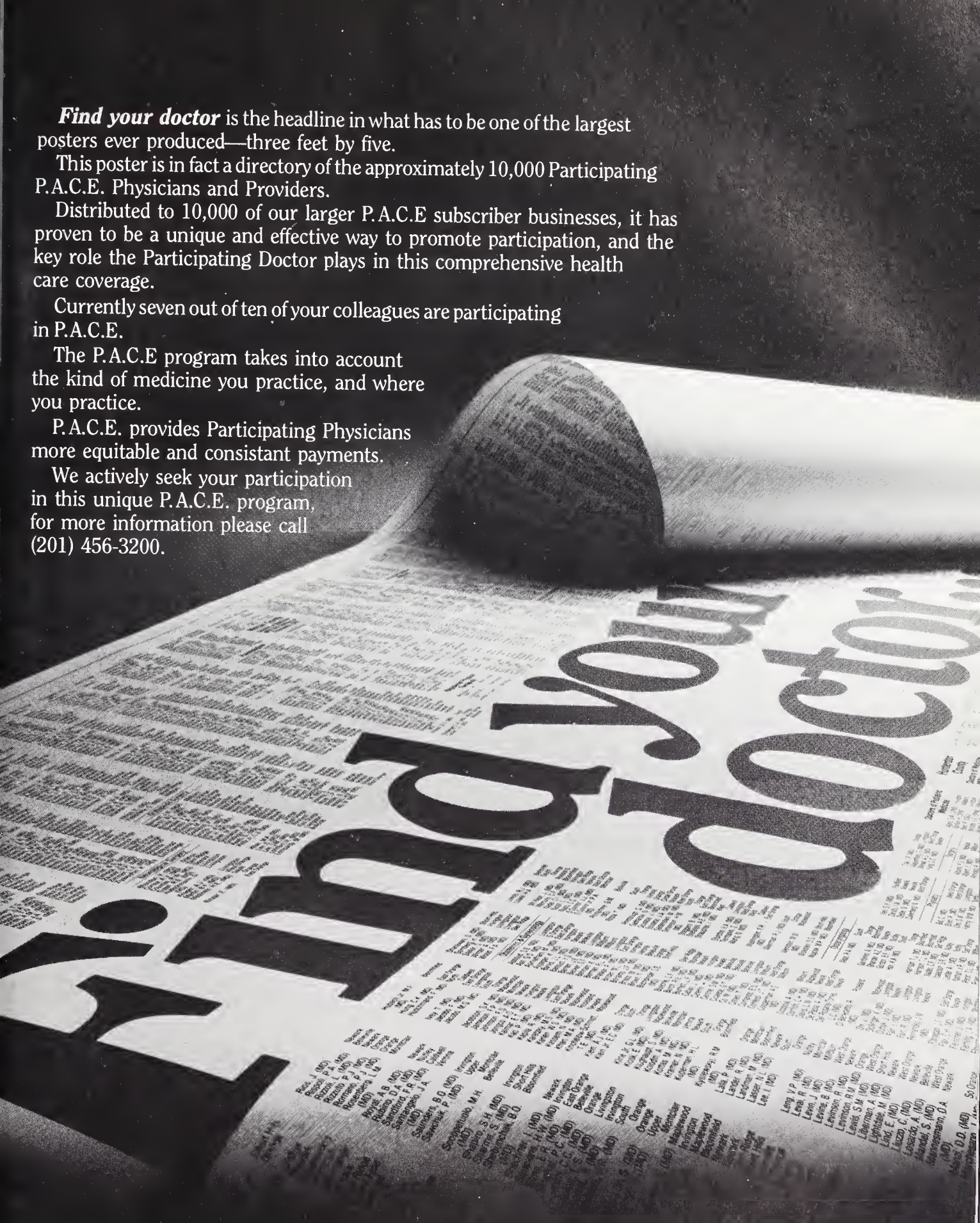
Distributed to 10,000 of our larger P.A.C.E subscriber businesses, it has proven to be a unique and effective way to promote participation, and the key role the Participating Doctor plays in this comprehensive health care coverage.

Currently seven out of ten of your colleagues are participating in P.A.C.E.

The P.A.C.E program takes into account the kind of medicine you practice, and where you practice.

P.A.C.E. provides Participating Physicians more equitable and consistant payments.

We actively seek your participation in this unique P.A.C.E. program, for more information please call (201) 456-3200.



The card that you can count on...

Blue Shield
of New Jersey

ONLY DALMANE®
flurazepam HCl/Roche
IMPROVES SLEEP...



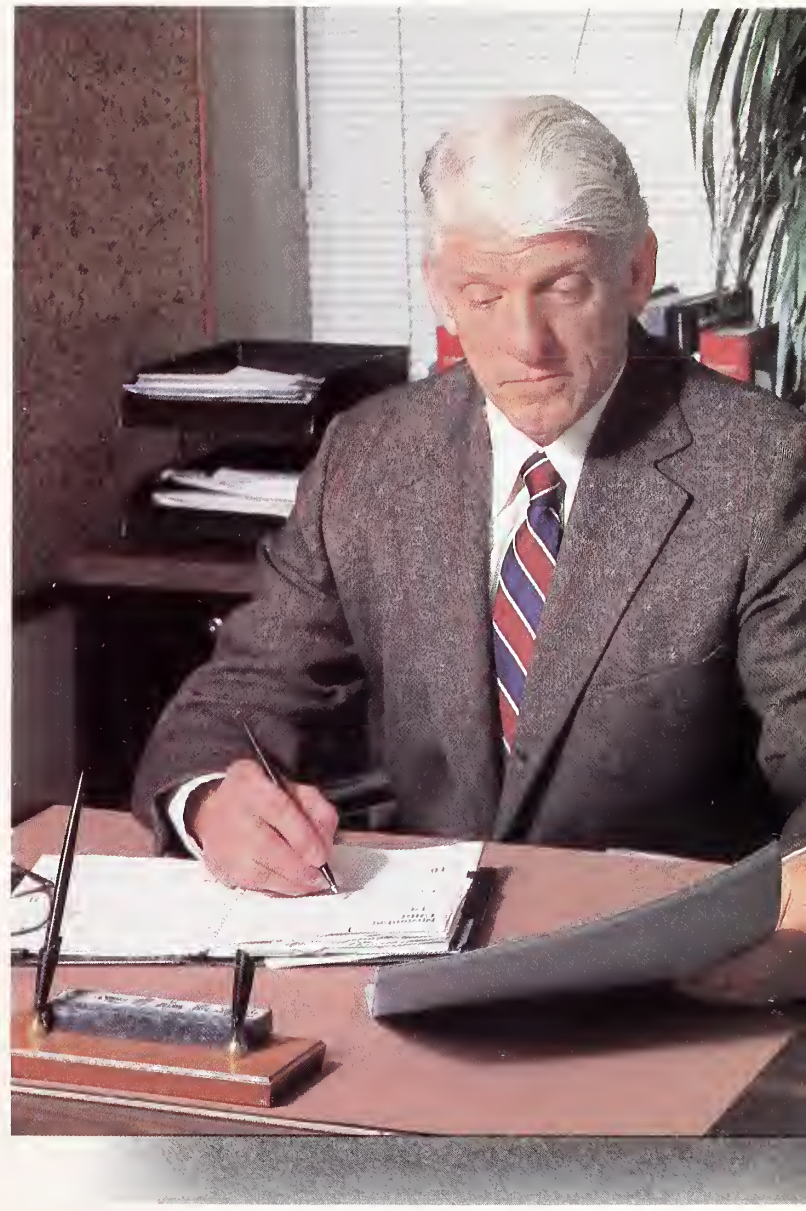
WITH
COMPLETE
SLEEP LABORATORY
PROOF[1-5]...

Copyright© 1984 by Roche Products Inc. All rights reserved.

N ALL THESE WAYS

- Rapid sleep onset[1-6]
- Effective for middle-of-the-night and early-morning awakenings[2,5]
- Undiminished efficacy for at least 28 nights[2-4]
- Patients usually awake rested and refreshed[7-9]
- Avoids rebound insomnia after discontinuation of therapy[3,5,10-12]

ution patients about driving, operating hazardous machinery or drinking alcohol during therapy. Limit dose to 15 mg in elderly or debilitated tients. Contraindicated during pregnancy.



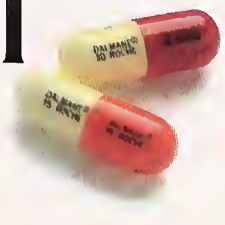
AND THE REDICTABILITY HAT COMES WITH XPERIENCE

FOR EFFECTIVE RELIEF OF INSOMNIA

DALMANE® (IV)

flurazepam HCl/Roche

STANDS APART



15-MG/30-MG CAPSULES

See next page for references and summary of product information.

References: 1. Kales J *et al: Clin Pharmacol Ther* 12:691-697, Jul-Aug 1971. 2. Kales A *et al: Clin Pharmacol Ther* 18:356-363, Sep 1975. 3. Kales A *et al: Clin Pharmacol Ther* 19: 576-583, May 1976. 4. Kales A *et al: Clin Pharmacol Ther* 32:781-788, Dec 1982. 5. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 6. Kales A, Kales JD: *J Clin Pharmacol* 3:140-150, Apr 1983. 7. Monti JM: *Methods Find Exp Clin Pharmacol* 3:303-326, May 1981. 8. Greenblatt DJ *et al: Sleep* 5 (Suppl 1):S18-S27, 1982. 9. Kales A *et al: Pharmacology* 26:121-137, 1983. 10. Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther* 21:355-361, Mar 1977. 11. Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. 12. Amrein R *et al: Drugs Exp Clin Res* 9(1):85-99, 1983.

Dalmane® Ⓜ
flurazepam HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

If your professional liability insurance company ran out of money, you could find yourself very much . . .

. . . alone.

We're 6,900 New Jersey physicians insuring *ourselves* through our own non-profit company. If you haven't joined us, you could be more at risk than you know. You owe it to yourself — and those that depend on you — to call us for more information.

800-257-6288

Do it now. Everything is at stake.



A professional service message from the
Medical Inter-Insurance Exchange of N.J.
Two Princess Road, Lawrenceville, NJ 0864
(609) 896-2404
*"The **Doctors'** Company"*

EDITORIAL

Physicians in the Mouse Trap

LEON G. SMITH, M.D.

Physicians must plan and work together. Be involved and address problems before we are legislated to death. The mouse trap is set.

During the past decade we have witnessed the greatest revolution in medical history. There ave been achievements well beyond our most imag- ıative dreams. Drugs (cardiac and antibiotics), de- ces (computed tomography and nuclear magnetic sonance), and procedures (endoscopy and angioplas-) all have added new dimensions to patient care. nfortunately, these achievements have accelerated bor costs of medical care astronomically. Intensive are which is daily care with continuous monitoring, nd one-to-one nursing along with aggressive medical ıtervention have placed costs at some centers at well ver $1,000 per day, per intensive care unit.

To cope with these new sets of events, our govern- ıent has devised new control measures geared to pre- ent the reoccurrence of the rapid rise of costs. Their rst attempt has been to contain hospital costs. The RG (diagnostically related group) system has been mployed even though "it has not been a system roven beyond the shadow of doubt." This typifies the ense of urgency of our already overtaxed medical sys- m. It is estimated that 1,000 of the hospitals in the nited States will close in the next year.

As we begin to adjust to this new DRG system, we ıust be made aware of the next phase of cost contain- ıent in the medical profession and its allied fields. The ext government attack will be multifaceted. First and remost, there presently exists a surplus, not only of octors and dentists, but of podiatrists, optometrists, ıiropractors, midwives, and psychologists, all of whom will be competing for the "shrinking dollar." What can we look forward to and how should we respond to the coming events?

Most notably, we shall witness creative efforts by doctors to attract new patients. Emergency centers, "no appointment needed" office hours, advertisement gimmicks, and new marketing approaches already are upon us. Staff doctors of the larger hospitals literally are fighting for emergency room rotations to ensure more patients. There is a growing demand for limitations of privileges in doing procedures such as colonoscopy and bronchoscopy. Hospitals are plagued with unending demands for the lucrative readings of EKGs and echocardiograms. Specialists are beginning to redefine their domains. Radiologists utilizing the computed tomography (CT) scan also are biopsying lung lesions while, at the same time, pulmonary specialists in the field of internal medicine are challenging the monopoly of radiologists who receive exclusive fees for interpreting CT scans of the lungs. Vascular surgeons resent the intrusion of radiologists in performing angioplasty. The new specialty in intensive medicine has been inhibited by pulmonologists, anesthesiologists, and gastroenterologists because the intensivist can do all of their procedures with equal skill. Cardiologists demand that all patients in the cardiac care unit obtain a consultation from a board certified cardiologist. Cardiac catheterization physicians vie with cardiac surgeons to insert pacemakers. Some hospitals have closed their medical staffs. Renal dialysis groups have discouraged young nephrologists from participating in their decreasing prosperity. Laser instrument use is restricted to a select few under the guise that excellence must be achieved by one before it can be transmitted to others.

While all of this is going on, the costs of malpractice insurance, medical school tuition, and office overhead continue to climb. Also, there is a growing body of newcomers called "medical whores." They are doctors who will testify against other doctors in the courtroom even under oath regardless of the truth. These greedy ones are driven in part because of exorbitant financial needs. Often, the young doctor is enormously in debt from educational expenses that he now must repay.

With new antibiotics like ceftriaxone, which has prolonged half-life, more patients with long-term hospitalization due to osteomyelitis, cellulitis, and endocarditis now can be treated as outpatients; this removes "chunks" of the physician's revenue for daily inpatient care. New corporations have sprung up all over the country providing total home health care. This venture further decreases hospital and physician care and revenue.

What shall be the net effect of these changes? There is little question but that doctors will have to settle for less income and a simpler way of life. Overhead expenses must be curtailed and a more careful search for the best place to start practice will be a must. My concern is that doctors by nature are rather narrow-minded, unimaginative people with chronic "free-floating" anxieties and, hence, may fixate on these major problems rather than pursue knowledge and excellence through education and teaching. I have noticed that physicians' attendance at grand rounds has decreased; free clinics participation is a rarity; and sur-

geons, on rare occasions, have transferred emergency cases to university and city hospital house staff rather than operate without a fee. There are fewer medical teachers and researchers.

I fear that the economics of medicine will control every aspect of our lives. If we do not maintain the dignity which we inherited from the dedicated physicians who came before us, then we have lost everything that is important in this life. The increasing preoccupation of physicians with business matters is not a healthy sign. Ironically, the students of the 1960s, who had soft lofty ideals, will be faced with medicine's greatest challenge. Optimistically, I predict that from all of this will emerge a new system: more efficient, far more governmentally regulated, and more competitive. Will it prevent the transfer of ill patients to a better facility? Will it shut out the newly trained physician? Will it impose political restraints on allied medical groups? Will the medical profession continue to receive the "god-like" respect held for them by the people?

I personally challenge each in the medical field to begin to think anew, to develop new plans, to work together, to curtail waste, and to reflect upon our new role in these changing times. Let us consider the following commandments:

1. There should be compromise between specialists without jeopardizing quality in the area of procedura domain. This will not be easy.

2. Monopolies and narrow lines of disciplines mus be eliminated.

3. We must plan and work together. If tensio heightens, as it shall in stress, then our emotions wil prevent rational solutions. I implore every physician i America to communicate now with your governmen Become involved and address these problems before w are legislated to death by an incompetent, ignoran and rigid bureaucracy. A passive role will lead to disas ter, with physician fighting physician, with variou medical ethnic groups banding together, and with th laity demanding a new system. The mouse trap is se Before we all become victims of our own greed, sha we run for the cheese or shall we jam the spring? Th choice still is ours but not for long. Shall our choic be imaginative planning and working together now o shall it be our crying out to legislators to free us fro the trap? The latter will cast us into a maze calle socialized medicine.

TAX PREPARATION AND PLANNING

- Individual, Partnership, Corporate, Business, Estate Services
- Expert Services
- Federal, Any State, Foreign Taxes of any type
- All Year Service
- Audit Representation
- Tax Planning and Reduction
- In Home or In Office Service

H. Michael Zukowski
(201) 945-8443

PROGESTERONE SUPPOSITORIES
25 mg., 50 mg., 100 mg., 200 mg., & 400 mg.
Boric Acid Suppositories 600 mg.

in both Polyethylene Glycol Base and Fatty Base for Vaginal or Rectal Use, are now being compounded at the following Pharmacy

Hidden Lakes Pharmacy

2039 Rt. #27, Somerset, N.J. 08873 201-821-8500
Howard L. Rubenstein, R.Ph.

Specific dosage and ingredient requirements can be tailored to your patients needs. We specialize in compounding prescriptions.

Delivery available to your patients home. Call for details.

NEW YORK FERTILITY RESEARCH FOUNDATION, INC.

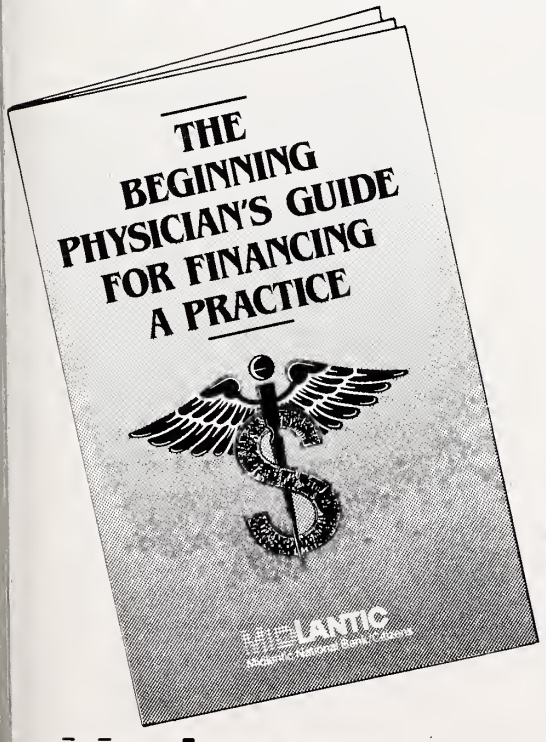
For the Investigation of
Problems of Human Infertility

The Foundation provides a complete diagnostic and consultation service for infertile couples. Investigations are conducted by well-known specialists in conjunction with consultants in the various fields of medicine related to infertility.

The Foundation is supported by an in-house modern laboratory equipped to do most tests required for diagnosis and treatment. Literature on request.

1430 Second Avenue, Suite 103
New York, N.Y. 10021
Phone: (212) 744-5500

Starting A Practice?...Already In Practice? Here's The Practical Guide You Need...FREE!



This booklet will assist you in developing and executing a strategic business plan that will enable you to secure the financing required to build a successful practice.

Written by David J. Shuffler, Vice President of Midlantic National Bank/Citizens and a specialist in medical practice financing, this new guide will prove invaluable.

For your free copy, call David Shuffler now at **201-894-5025** or mail the coupon below.

Mail To: David J. Shuffler, Vice President
Midlantic National Bank/Citizens
1 Engle Street, Englewood, NJ 07631

Please send me my free copy of **The Beginning Physician's Guide for Financing a Practice.**

NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
PHONE _____
☐ RESIDENT ☐ IN PRACTICE
SPECIALTY _____

MIDLANTIC
Midlantic National Bank/Citizens
Offices Throughout Eastern Bergen County. Member FDIC.

Just once each day...

First-step blood pressure control with optimal simplicity

Benefits diuretics cannot offer . . . Once-daily INDERAL LA (propranolol HCl) provides smooth, 24-hour control of blood pressure plus the cardiovascular benefits of the world's leading beta blocker. And INDERAL LA provides a high degree of patient acceptance—without potassium problems.

Experience no other beta blocker can match . . . Once-daily INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.



Start with 80 mg once daily... Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



80 mg 120 mg 160 mg

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

Just once each day for initial therapy in hypertension.

Ayerst

Just once each day for initial therapy in HYPERTENSION.

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease; elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with chills and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.
PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

8950/2

Ayerst® AYERST LABORATORIES
New York, N.Y. 10017

Selection of a Medical Office Computer System

James W. Allen, M.D., River Edge*

Selection of a computer system for an office requires understanding of the computer marketplace as well as personal needs. The computer marketplace has three distinct segments offering different approaches to computerization. Functionality, support, and price summarize a physician's computer needs.

No physician can ignore computer advertisements in the medical and lay press that claim ıntastic benefits at an amazingly wide range of prices. hese benefits certainly would attract any cost-con-ıious physician. Realizing these benefits, though, re-uires addressing several issues. First, the doctor must :arn computer jargon. Only when you have mastered ·rms like hardware (the computer itself), software hat which makes the hardware operate), "byte" (one ıaracter), and "mass storage devices" (such as floppy iscs or Winchester technology), can you describe suc-:ssfully your needs for automation. Next, the phy-ıcian must ensure that the office staff will support ɔmputerization. Finally, the doctor must learn from ıe horror stories told by colleagues who had unsuc-:ssful attempts at automation. Some doctors in-efinitely postpone a decision to automate because of ıese issues. For those who do come to terms with ıese factors, the final decision becomes: which in-ouse computer is "best" for the practice.

Like the decision to automate, the decision to urchase can be exasperating. Only price seems to ifferentiate vendors who offer seemingly similar com-uter systems. The temptation is to choose a system ased solely on price. I propose an alternate selection ıethod which looks at the characteristics of the com-uter marketplace as well as the individual practi-oner.

MEDICAL COMPUTER MARKETPLACE

Just as diabetic patients fall into categories such as adult and juvenile onset, the vendor of medical computer systems has definite characteristics. Some of these differentiating characteristics are the distribution method, support provided, and system expandibility (Figure 1). Using these characteristics, medical vendors fall into the following categories: mail-order companies and large distributor chains who sell software for popular personal computers; vendors selling business computers specially programmed for physician office automation; and local dealers or computer consultants who provide specially tailored systems.

A physician can purchase medical office billing software by mail-order or through an electronic dealer network. This software usually requires the popular Apple or Radio Shack computer along with one to three disc drives for floppy disc storage. With the software comes instructions on converting your present manual accounting system to computerized system. Typically, neither the software vendor nor the hardware supplier provides much individual support. Purchase price is less than $10,000 for hardware and software.

Some vendors are developing special expertise in the

*Dr. Allen is a computer consultant and Instructor in Clinical Pathology, Columbia University College of Physicians and Surgeons, New York. Correspondence may be addressed to Dr. Allen, 181 Jefferson Avenue, River Edge, NJ 07661.

"vertical" market for medical systems. From these vendors the physician purchases a complete system, both hardware and software, as well as training, system support, and site preparation. These vendors typically use business computers such as IBM, ALTOS, Alpha Micro, or DEC and use Winchester type hard disc. In addition to medical accounting, these vendors can supply enhanced software that will perform appointment scheduling, special report writing, word processing, diet analysis, and other functions. Price for the basic system starts at about $20,000.

The final category in the computer marketplace is local vendors or freelance programmers who will write computer software to your specifications. You must outline for them the specific task that you want accomplished. These vendors then can write the software and select the hardware that is best suited to your needs. Finding a good freelance programmer is difficult. Costs easily can mount due to programming bugs and vague specifications.

PHYSICIANS' NEEDS

Functionality, support, and price summarize a physician's requirements for an office computer system. The relative importance of each of these categories depends on the physician's practice and temperament.

Functionality implies the ability of the computer system to meet present and near-term (two to five years) requirements. Data storage capacity is very important in satisfying the functionality requirement. To estimate storage needs, you must determine the number of bytes of data you expect to process. Figure 2 shows some helpful guidelines. The total number of bytes determines the type of mass storage device. Commonly used storage devices are floppy discs, hard discs, and Winchester technology drives. These devices are a significant factor in the total hardware cost of a computer system.

Other requirements contribute to the total functionality of the system. Commonly forgotten is an appreciation for:

- The number of different statements or insurance forms to be completed, now and in the future;
- The likelihood that the system must perform multiple operations, such as printing and data input at the same time (multitasking);
- The need for future enhancements, such as word processing, dietary analysis, and spread sheet capabilities;
- The possibility of communication between your office system and another computer located in your home or on a computer network;
- The ease with which the software can be customized to match the documents used in your practice.

By appreciating these requirements, you can better define the true functionality of a computer system in your office in addition to storage capacity.

In establishing your support requirements you must ask yourself questions on your needs for training and documentation, system reliability, and service availability. Vendors provide training programs (on or off site), and support through telephone linkages. The level of staff interest and the staff turnover rates will determine how much of these services you will need.

Mail-Order Distributors, Mass Distributors
- Purchaser installs system
- Dedicated to one task, i.e. billing or word processing
- Limited system support
- Relatively small data storage capability

Vendors Dedicated To Supplying Physician Office Systems
- Installation and training provided
- Expandable to numerous tasks
- Complete system support
- Wide range of data storage capabilities

Specially Tailored Systems
- Matches your specific needs

Figure 1—Characteristics of the medical computer marketplace.

Per Patient Estimates	
Name and address	200 Bytes
Financial/insurance	2000 Bytes
Medical/prescription	2000 Bytes
Per physician estimate	4,000,000 Bytes

Example: An estimate of storage requirements for name, address, and financial/insurance data on 10,000 patients is 22,000,000 bytes (10,000 x 200 + 10,000 x 2,000)

Figure 2—Guidelines for determining data storage requirements.

Obviously, a practice with high turnover in staff will require more training and support than one with a stable staff. System reliability and vendor responsiveness to service requests also are important aspects of your support requirement. Several steps can help you access these requirements. First, visit a colleague with a system similar to the one you are contemplating purchasing. Just observing the system's operation will answer many questions. Then, ask yourself these additional questions: How long could my system be down without hurting the practice? Will dealing with multiple vendors for hardware and software support cause me inconvenience? What ties does my practice have to a computer service organization? Improper assessment of the support requirements accounts for many of the horror stories you hear about medical office computer systems.

Price limitations are a requirement all of us must face when making major purchases. Three prices are important in a computer purchase: acquisition costs, operating expenses, and enhancement fees (Figure 3). Computer equipment qualifies for both investment tax credit and depreciation expense, so your out-of-pocket costs may be less than the stated purchase price. Many computer vendors provide an equipment leasing option to reduce large capital outlays. Remember to include in the price of the system the costs for site preparation, such as electrical and carpentry work, power conditioners, antistatic mate, shipping charges, and other necessities. Operating expenses for a computer system include costs of paper, supplies, and vendor support. With a computerized system each physician uses approximately $4,000 of paper products per year.

Acquisition Cost Options
- Purchase price reduced by investment tax credit and depreciation expense
- Lease

nstallation and Site Preparation Costs
- Electrical and carpentry work
- Shipping
- Antistatic mats
- Power stabilizers

)perational Expenses
- Paper and supplies—3 percent per month or $4,000 per physician per year
- Vendor-support contract—1 to 2 percent per month

Enhancement Fees (cost of common enhancements)
- Word processing
- Dietary analysis
- Spread-sheet capabilities

gure 3—Considerations in price comparison.

n a monthly basis these consumable supplies rep-sent about 3 percent of total system purchase price. ld to this the monthly cost of vendor support, typi-lly 1 to 2 percent of the total purchase price. As part this support contract, most vendors will supply new eases, i.e. modifications of existing programs, at no ditional charge. However, if you plan to enhance the pability of your system, such as adding word proc-sing, then plan on paying for this enhancement. edless to say, in defining your price requirements nsult your tax advisor and accountant.

)MPUTER SELECTION PROCESS

As an alternative to comparing systems solely on the sis of price, our selection process involves two steps. rst, the physician evaluates the functional needs, pport requirements, and price limitation of the prac-e. Then, the physician identifies the market segment ost likely to meet those needs. Several cases will il-strate this selection process in action.

Case 1: Growing practice in a major metropolitan ea with much third-party billing. Requirements: The mediate needs are for third-party billing and rec-dkeeping; however, the group expressed strong erest in an appointment scheduling system as well recording of patient clinical data. The large size of e practice indicates a large volume of reports with need for multiple terminals, each performing a dif-ent function. None of the physicians have special erest in computing. Office staff positions are stable, cept for clerical personnel who most frequently uld use the terminal. Financial analysis shows that 0,000 is the maximum cash outlay available for the stem. Recommendations: This practice should rchase a complete system from a vendor specializing medical computing. Factors influencing this rec-mendation are the multitask requirements, low el of inhouse computer experience, heavy computer workload, and system expansion requirements. Because of the practice location, a variety of system vendors will have local sales and support organizations.

Case 2: Older solo practitioner who requires patient billing capability. Requirements: This physician has been in practice at the same location for many years. As a result, the practice has strong ties with local merchants including the manager of a consumer electronics store. Because most patients pay in full after each visit, the doctor's billing requirements are not large. The office staff is very stable and very enthusiastic about a computer. Recommendations: An enthusiastic staff and close ties to a computer dealer suggest that this practice could generate much internal computer support. In addition, the practitioner's small practice size and limited computer needs do not require large computer capability. In this situation the physician should choose software that can be implemented on a popular personal computer.

Case 3: Two-man practice with one partner having definite computer interests. Requirements: As a result of college training and much personal interest, one partner has become quite skilled in computer programming. He envisions a system that records basic patient demographic data, progress notes, and accounting records. Already, he has completed some of the programming for the system. His partner also is very enthusiastic about the proposed system. Recommendations: Probably no commercially available system will satisfy these physicians. Before starting to create their own system, they should be cautioned against "reinventing the wheel." A good approach is to customize an existing system for their specific needs. These physicians probably are well aware of the need for definite specifications and the high cost of freelance programmers. If the partners properly direct programmers, they will have a system exactly tailored to their needs.

YOUR COMPUTER DECISION

This article may help you to appreciate the segmentation of the marketplace for medical computer systems. Each segment offers a different approach to your data processing needs. You best can understand your own unique needs by describing your requirements in terms of functionality, service, and support. The recommended readings will help in your requirements definition. My approach to system selection is to apply your requirements to that market segment most likely to meet your needs. Failure to make comparisons of vendors within market segments is like choosing between apples and oranges based only on price.

REFERENCES

1. Auer J, Harris C: *Computer Contract Negotiations.* New York, NY, Van Nostrand Reinhold Company, 1981.
2. Cohodes S: Computer boosts monthly collections by 35 percent. *Physician's Management,* 137-141, 1981.
3. Enlander D: *Computers in Medicine, An Introduction.* St. Louis, MO, C. V. Mosby Company, 1980.
4. Shaw DR: *Your Small Business Computer.* New York, NY, Van Nostrand Reinhold Company, 1981.

WHY AMA?

Through the AMA library you can have immediate access to a vast store of medical, scientific, and socio-economic information. The library maintains a large collection of books, journals, and microfilm and provides instant on-line access to countless information sources through computerized data bases. The AMA library: it's one more good reason why you should be a part of the AMA.

To Join,
Contact your county or state medical society or write: Division of Membership, AMA, 535 North Dearborn Street, Chicago, Illinois 60610 or call collect, (312) 751-6196.

AMA
AMERICAN MEDICAL ASSOCIATION

References:
1. Stone PH, Turi ZG, Muller JE: Efficacy of nitedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY
PROCARDIA® (nitedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any ot the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request. © 1982, Pfizer Inc.

Pfizer LABORATORIES DIVISION
PFIZER INC

"I can do things that I couldn't do for 3 yrs. including joining the human race again."



Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

© 1983, Pfizer Inc.

"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA *brief summary on adjoining page.*

JMK

BMW

SAAB

Our reputation has been built on our SERVICE



JMK AUTO SALES

391 Rt. 22 (East) Springfield, New Jersey

379-7744

The Psychological Impact of Cancer on Patient and Family

Barton A. Singer, Ph.D., Cherry Hill*

The psychological impact of cancer on the patient and the family almost can be as traumatic as the physical effects. Patient and family must deal with marked changes in the family structure and feelings of isolation, loneliness, helplessness, and dependence. Denial, isolation of affect, and rationalization are discussed.

The psychological impact of cancer on the patient and the family almost can be as traumatic as the physical effects. Realistic as well as unrealistic stresses and fears are aroused which can overwhelm the individuals who have to cope with them. To be faced with the anticipation of dying from cancer with all the connotations and implications that usually are associated with this illness, is to be struck with one of the ultimate painful emotional events in life. However, because it is human nature to try to avoid the experience of pain as much as possible, it often is extremely difficult for cancer patients and their families to relate to each other and deal with their problems in a constructive way. Psychological defense mechanisms are utilized to an excessive degree in order to keep threatening thoughts and feelings from conscious awareness and from overwhelming the individual. Consequently, important personal issues are not dealt with so that tensions and conflicts among family members usually are increased.

PSYCHOLOGICAL CONSEQUENCES OF THE ILLNESS

Psychological stresses facing families with members who have cancer have been described at length in the literature.[1-5,7,8] The intense physical pain of the illness and/or the treatment, the difficulty in accepting that one's life soon is to end, the helplessness and inability to do much for oneself to influence the disease, the uncertainty of treatment outcome, the physical changes in one's body, the catastrophic financial burden, and the alterations in family patterns and roles are all consequences of the illness that cannot be avoided to any great extent. Adding to these realistic hardships, however, are those that are brought about by the individual's unadaptive coping mechanisms which exacerbate a terrible situation. When certain aspects of reality are distorted or ignored and when expected and understandable feelings are part of the family atmosphere but not recognized and talked about, conflicts fester and hardships are magnified. For example, the impending death of a parent usually necessitates modifications in the family structure that should be planned for and discussed. Role changes are required. The working husband may have to become more responsible for child care and homemaking duties. A wife who has been used to having her husband handle the finances must become familiar with economic realities. Often the children are not able to continue participating in certain activities because no one is there to transport them or there may not be the necessary funds to pay for them. These deprivations especially are hard for many children to accept because

*Dr. Singer is a clinical psychologist in private practice in Cherry Hill. Correspondence may be addressed to Dr. Singer, Executive Mews, D-19, 1930 E. Marlton Pike, Cherry Hill, NJ 08003.

they often are left out of important family discussions and they do not have a clear idea about the problem facing everyone. Most family members have a natural resentment toward these changes to some extent. If these negative feelings are not recognized and understood, however, the anger felt towards a sick loved one can stir up so much guilt and increased resentment that constructive readjustments almost are impossible to make.

For example, a patient was told that he had about two years to live. An industrious, hard-working, overly independent man, he had been the traditional sole provider who assumed complete control of the family financial situation. Because his wife accepted her conventional role so completely, this aspect of their relationship had not caused any apparent difficulty until the illness was diagnosed. At that time, she realistically started to worry about their income and financial resources and asked her husband systematically to record their assets so that she would have an accurate appraisal of the situation. For one year, her husband said he was going to comply but he never was able to complete the task. To do what was required, would be to admit to himself that he would be dying soon. Consequently, he continued to deny the necessity of completing the record, rationalizing that he still had plenty of time. Often, he repressed the project until his wife mentioned it again, at which time he would become very irritated and accuse her of nagging. While he could say that it made sense to do what she wanted in order to relieve her anxiety and her uncertainty, he could not bring himself to do it; this significantly increased the tension between the couple.

Denial usually is considered a primitive defense because it often can bring about a significant and dangerous distortion of reality.

Feelings of isolation and loneliness typically are experienced by the patient with cancer, brought about in part by the realities of the illness. Many families spend inordinate amounts of time away from other healthy people. Going to hospitals and undergoing treatments take up so much time and energy that there is little left over for socializing. Furthermore, some healthy people tend to shy away from the critically ill and feel uncomfortable when patients talk about their illness. Adding to the situation, however, is the patients' and the families' reluctance to think about and talk about certain unpleasant aspects of their predicament. Often, what is foremost on the patient's mind is some serious and depressing complication related to his sickness. No one wants to discuss it. Yet, it is hard to find something else to talk about; everyone in the house keeps quiet or searches for something "pleasant" to say. Because the patient is not able to express freely what really concerns him, he often feels that no one understands or cares about him, which increases his sense of isolation.

During the course of the disease the patient typically becomes weakened, helpless, and dependent on others. The patient is not able to work as effectively as before. Help from others is required. But the patient may be reluctant to accept the fact that assistance is necessary. Dependency can be denied so long that it often is very difficult to bring about the necessary readjustments.

One patient, a compulsive homemaker, saw herself as the mainstay of the home. All decisions were made by her and all family activities were initiated by her. After a mastectomy, she pushed herself to maintain a facade of normalcy, exhausting herself by an excessive effort to keep the house clean, care for the children, drive them to activities, and work part time. While she could not fully admit to herself that she had slowed down, she did resent her family's inability or unwillingness to detect her gradual decline and offer to help her. By the time she finally had reached her limit and asked for help, she was bitter and resentful. But her husband and children found it hard to understand her situation and resented how and what she requested; she did not look sick. Why couldn't she continue to do what she always had done? For an unfortunately long time, her husband directly refused to do household tasks; that was not part of his role definition as husband and father.

DEFENSE STRATEGIES IN THE CANCER FAMILY

When defense mechanisms distort reality and hide feelings, the individual cannot cope with significant interpersonal difficulties in the most adaptive way. And because the painful feelings, thoughts, and events associated with cancer are so traumatic and devastating, the utilization of defenses particularly is excessive and pervasive in this clinical population. Furthermore, defensiveness between members of the family characteristically is higher than with other people; intense, deeply personal familial relationships often are complicated by long-standing unresolved conflicts and family members frequently are reluctant to be frank and open with their spouses or children. People typically fear that if they are more direct in communicating their concerns, pains, and needs they will be rejected or they will upset the loved one. Therefore, it is easier to talk more honestly with a neutral professional than with a relative.

One of the more prominent defenses seen in the cancer patient is denial, which involves denying or negating facts and feelings that would be painful to acknowledge; the person believes that he has no awareness of or responsibility for an event or feeling that actually exists. Denial usually is manifested in the reversal of a painful fact, e.g. "I'm not so sick." When a patient denies that he has any problems, it is hard to help him. This particularly is dangerous for the cancer patient where life can be endangered. A woman who feels a lump in her breast and says to herself, "It is nothing," does nothing about it. A young married man with a brain tumor has a great need to emphasize that he still can do most of the things that he used to do before his illness, like ride a bike in traffic or jog. It still is hard for him to accept his limitations; he must continue to deny many aspects of his declining condition.

Denial usually is considered a primitive defense because it often can bring about a significant and ngerous distortion of reality. At times, however, it so can be an adaptive healthy maneuver; most pa-nts have to deny some aspects of their circumstance certain junctures in the course of their illness in der to reduce the impact of the traumatic event. One nnot face death all the time. This defense helps the tient to carry on with life and to do what living one able to do. Consequently, the doctor and relatives ed to respect denial and not push the patient to cept the reality of his illness any faster than he is lling and/or able to. While many patients do want know the facts about their sickness, some do not d they can deteriorate emotionally and physically nen they are informed too bluntly. It takes considerle psychological sensitivity to deal with denial effecely and to present "the facts" in a therapeutic way.

A more efficient defense mechanism than denial is olation of affect. When this defense is operating, the nnection between ideas and feelings are severed so at the person is calm in a situation where strong notion would be appropriate and expected. With olation, patients can talk with equanimity about tentially disturbing subjects like their impending ath or the excruciating pain. Unfortunately, how-r, isolation can prevent them from coming into imediate contact with their feelings in order to express em and then be relieved of some of their impact. The following is an example of how isolation of affect s therapeutically reduced in a treatment situation: eenage boy explained that, although he knew his her was very sick, he was not able to get in touch th his feelings about this fact. It took him a long time nsciously to become aware of the warded off feelings d to be able to cry and to talk to his father openly out his dread and his fears of what life would be like nen he is gone. Before this time, he felt unable to ate to him and to help him. He usually kept his tance from his father and kept his thoughts to nself.

Another prevalent defense manifested in the family cancer patients is rationalization. This mechanism nsists of explaining away and trying to justify oughts or a course of action by finding an excuse support a point of view that is more acceptable than real reason.[6] Usually the rationalization takes the m of "false altruism." One family member keeps nful information from another in order to avoid posing a burden, something that could not be enred. Spouses hesitate to inform the patient about dical developments, patients do not want to discuss tain problems with their spouses, and most parents l their children are too young to comprehend. or example, a patient was reluctant to talk about diagnosis with his teenage son even though he cussed it with many other relatives. The son knew ut it because he was at the hospital when the famfirst was informed. Yet the father stated that he was young to be encumbered with such horrible news ing: "He would not really understand." Furtherre, even when the patient was enduring excruciatpain and was so depressed that he felt he could go on living, he held back tears because he did not nt his wife to find out how depressed he was. He feared that she would get more upset and frightened.

In most cases these kinds of rationalizations are excuses which serve as a means to protect individuals from becoming more completely and directly aware of the painful feelings that they are strenuously trying to hide from themselves. Such individuals do not want to deal with the unpleasant issue, so they tell themselves that they are avoiding it out of concern for the other person.

Because of this excessive defensiveness, feelings are cut off from conscious awareness. Consequently, closer, more effective, and spontaneous communication is inhibited and certain aspects of reality are distorted and not dealt with adaptively. Furthermore, when defense mechanisms against becoming aware of unpleasant feelings are operating to a pathological extent, it is difficult for the individual to integrate and modulate them. These affects remain unconscious but active and powerful in affecting one's behavior. In order to work through and accept the anger, sadness, and loss and in order to mourn the psychological and physical deprivations, the cancer patient and the family have to become aware of the emotional events experienced, accept the feelings, and express them. This usually results in some relief from their impact. But because of their excessive utilization of defense strategies, this psychological task is hard for these patients to accomplish on their own. Some professional help often is required to assist the family in not avoiding issues that must be faced.

Particularly for this clinical population where there is so much emotional pain to defend against and where defensiveness is increased because of the family atmosphere, counseling can be valuable. It allows families to focus on and deal more adaptively with traumatically threatening feelings and conflicts which, when present but unacknowledged and avoided, create massive blocks in communication, impasses which add a further burden to an already intolerable situation. While the patient with cancer clearly benefits from participation in counseling, it may be the family members who gain the most. Obviously, they are the ones who live longer and can continue to carry the burden of guilt and unresolved mourning for a long time. The death of a loved one often stirs up old conflicts and resentments. Helping them to deal realistically with the illness, accept death, and go on to live their lives unencumbered by neurotically conflicting feelings may be the most significant treatment goal.

REFERENCES

1. Bowers M, Jackson E, Knight J, LeShan L: *Counseling the Dying.* San Francisco, CA, Harper & Row, 1981.
2. Eissler K: *The Psychiatrist and the Dying Patient.* New York, NY, International Universities Press, 1955.
3. Giacquinta B: Helping families face the crisis of cancer. *Am J Nursing* 18:1585-1588, 1977.
4. Hackett TP: Psychological assistance for the dying patient and his family. *Ann Rev Med* 27:371-378, 1976.
5. Kubler-Ross E: *On Death and Dying.* New York, NY, Macmillan Publishing Co., 1969.
6. Laughlin HP: *The Neuroses.* Washington, D.C., Butterworths, 1967.
7. Pincus L: *Death and the Family.* New York, NY, Random House, 1976.
8. Sontag S: *Illness as a Metaphor.* New York, NY, Vintage Press, 1979.



Angina Protection with Benefits for a Lifetime

ONCE-DAILY CONTROL WITH HEART-SAVING BENEFITS

By reducing heart rate and cardiac contractility, INDERAL LA helps protect the heart from the potentially serious and debilitating consequences of ischemia. A highly effective antianginal agent for around-the-clock control of symptoms, INDERAL LA also provides cardiovascular protection for a sense of security in the years ahead.

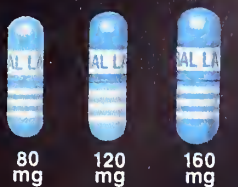
PROTECTION AND EXPERIENCE NO CALCIUM BLOCKER CAN MATCH

Unlike calcium blockers, INDERAL LA—either alone or with a nitrate—is recommended for early treatment of angina in the majority of patients. Equally important, INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use.

START WITH 80 MG ONCE DAILY

Dosage may be increased to 160 mg once daily, as needed, to achieve optimal control. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY **INDERAL LA** (PROPRANOLOL HCl) LONG ACTING CAPSULES



Ayerst®

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

JUST ONCE EACH DAY FOR SIMPLIFIED CORE THERAPY IN ANGINA

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block, hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 240 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.
PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

8833

Ayerst AYERST LABORATORIES
New York, N.Y. 10017

Medical History: Alabama Granny Midwife*

Linda Holmes, M.P.A., Newark**

Segregation, racism, agrarian economics, and isolation forced the majority of Alabama's rural black women to utilize the services of a granny midwife in past days. Current practitioners are incorporating some techniques identical to granny midwife management approaches during labor and birth.

The history of Alabama's Afro-American midwifery practices must be viewed within the parameters of the black experience in the rural South. As recently as 1950, segregation, racism, agrarian economics, and rural isolation forced the majority of Alabama's childbearing black women to rely on the self-help mechanisms of folk practitioners. Hence, the long-term isolation of rural blacks from many aspects of western medicine's influences and controls created an environment ripe for the survival of the "granny midwife." In direct contrast, inhospital physician-managed childbirth was the well-established norm for white Alabama women.

It is not surprising that so little that is positive ever has been written about the granny midwife; historically, granny midwives in America's southeastern states primarily have been older, empirically trained, low-income black women who were tolerated by physicians as necessary evils.[1] Now, when granny midwifery practices have been eradicated or soon will die, only rare self-descriptions of granny midwifery work exist.

I went to Alabama in 1981 for seven months to record interviews with the state's last generation of granny midwives. Alabama discontinued the issuance of lay permits for the practice of midwifery in 1976, yet I was able to obtain a 1977 Midwife Roster compiled by the State Health Department containing the names of over 150 lay midwives. By 1981, however, the majority of these midwives had retired or had been forced out of business by local health department officials; others had died. I recorded interviews with 7 individuals who never had practiced as midwives, but were familiar with folk practices and beliefs surrounding childbirth. These persons were valuable informants in confirming midwifery roles.

The interviews revealed that while the long-term survival of midwifery practices directly was related to prevailing socioeconomic circumstances, midwifery work did enrich the life experiences of many southern black women.

This paper will discuss three aspects of midwifery work which have affected positively southern Afro-American communities: midwifery practices have supported African-based traditions; midwifery has contributed to the health of mothers and babies; and midwifery practices have increased decision-making opportunities for black women.

TRADITIONS

Prior to the demise of granny midwifery practices,

*Read before the Medical History Society of New Jersey.

**Ms. Holmes is an Assistant Professor, UMDNJ-School of Health-Related Professions. Correspondence may be addressed to Ms. Holmes, UMDNJ-School of Health-Related Professions, 100 Bergen Street, Newark, NJ 07103.

midwives acted as significant tradition bearers in their everyday work. Midwifery apprenticeships, in particular, provided formalized mechanisms for passing on various cultural expressions and knowledge. In the interviews, many women recalled the specifics of how they maintained a culturally appropriate rubric for the labor, delivery, and postpartum process. Some practices that reflected African traditions included officiating in rituals such as the disposal of the afterbirth and presiding at taking up ceremonies—a prescribed ritual for the reintegration of the mother into her everyday role following childbirth. The midwives also described practices similar to African rituals which dictated that during the postpartum seclusion period, no fire may be removed from the house and that no house may be swept.[2] Several Alabama midwives spoke of similar taboos against sweeping under the bed and the removal of ashes from the fireplace.

The following is one mother's description of the midwifery role in prescribing behavior to be followed after childbirth:

> Well, when the midwife came back and she took me up and I remember her giving me a dose of medicine and it was some castor oil to get all the filth and stuff out of you, so they told me. And then you had to walk all the way around the house and come back. It would be up in the day [late in the day]. If it was in the wintertime, they would make sure it would be a nice warm day. The coldest time I had a baby was in March. The midwife would not let me go outside on that day. She waited till she found a better day. She came and she got me up, but she made sure I was back in the bed before she left .... It would be a month before they threw the ashes away. If you smoked a cigarette in there, you couldn't take it out of there. You couldn't take no fire out of the fireplace where they burned the afterbirth.

Other Alabama practices that paralleled traditional beliefs included divine calls to practice, belief in the power of prayer throughout the birthing process, and reliance on divine guidance in crisis situations. In general, the granny women strongly resisted creating dichotomies between the secular and the religious; their midwifery work was reflective of this view. While many midwives requested fees for service—many recalled charging $5.00 per birth when they began their practices—midwives often provided care as a God-given duty without expecting cash payments.

MATERNAL AND CHILD HEALTH

In viewing midwifery work, the most critical aspect of her practice was in her ability to assist in the birth of a healthy baby while safekeeping the health of the mother. Today, the total dominance of medicine in the baby delivery business obscures the fact that healthy spontaneous birth is the norm in the overwhelming majority of childbirth cases with minimal or no technological intervention required. Since the 1960s, when consumers began to demand more decision-making power in the birthing place, greater attention has been given to the view of childbirth as a basically natural and normal family-centered event. Ironically, as granny midwifery practices die, modern health care professionals and consumers who accept this childbirth perspective rapidly are incorporating various techniques and management to labor and birth which are identical with the age-old granny practices; the efficacy of such practices now is being confirmed through various research efforts. There is increasing scientific evidence, for example, that it is advantageous to keep mothers ambulant during labor and that encouraging other than flat-on-the-back, feet-in-stirrups, delivery table birthing position is beneficial. In the interviews the granny midwives frequently talked about keeping mothers stirring "as long as they could drag" and often defied health department ultimatums demanding that mothers give birth lying in bed.[3] The use of massage with various oils during labor and birth, often referred to by the granny midwives, also is popular among modern midwives. Even the midwives' everyday pharmacopoeia including teas, herbs, and household remedies such as castor oil are regaining popularity for their effectiveness during labor and birth.[4] There were extreme differences among the midwives interviewed regarding their admitted familiarity and use of natural herbs and home remedies. Since the 1890s, when the issuance of midwifery permits began in Alabama, health department officials adamantly have opposed the use of any herbs or medications by midwives. Yet all the midwives interviewed expressed familiarity with the use of castor oil as well as black pepper tea and dirt dauber's tea as stimulants for labor even if such teas never were used by them in their own practices.

Granny women strongly resisted creating dichotomies between the secular and the religious; their midwifery work was reflective of this view.

It must be noted that this research project did not formally include collecting midwifery statistics. In the course of midwifery interviews, however, several of the more active midwives who reportedly attended more than 500 births, recalled 5 or less stillbirths and one or no maternal deaths. Due to the frequent lack of formal medical backup and the inclusion of high-risk patients in midwifery caseloads, many granny midwives functioned well beyond the accepted scope of both the modern lay and nurse midwife; yet, many of these women reported outstanding maternal and infant mortality/morbidity records.

DECISION MAKING

The supervision of midwifery work by local health departments was said to have ranged from extremely laissez-faire attitudes to close working relationships with midwives. As long as other health care options were inaccessible to blacks and as long as women continued to value birthing customs, many midwives could exercise a high degree of decision-making responsibility in the privacy of the home setting. Examples of independent decisions which had to be made in the management of labor and birth included: whe

nd to what degree the mother's activity should be estricted during labor; whether to administer any erbs, teas, or other medications; and whether to enourage alternative birthing positions. If unexpected nergencies such as a retained afterbirth or multiple irth presented themselves, immediate decisions were quired regarding the feasibility of seeking emergency edical care. In many instances, midwives had to deide whether it made more sense to test their technical pabilities or to begin the often complicated process seeking transportation and finding a hospital where physician would be willing to provide care to an digent black woman. Besides making management ecisions, the midwife often literally took charge of the ousehold matters as well. She frequently decided who ould be permitted in the birthing area and she exected family members to act as supporting personnel d to carry out whatever orders the situation deanded.

The other significant aspect of control that midwives d in their work was in the selection and training of prentices. By tradition, midwives acquired their ills through observation sessions and training with nior midwives, therefore, the senior midwives were le to maintain powerful positions in determining o entered midwifery ranks. Even when health dertment officials actively were recruiting younger dwives, senior midwives reportedly denied certain cruits observational experience if these women failed meet their standards of eligibility for midwifery rk. Having good nerves, demonstrating spiritual mmitment, actively attending births in the comunity over an extended period of time, exhibiting oral behavior which was in keeping with senior midves' own personal values, and having a midwifery nily lineage were among the criteria most frequently ed by senior midwives in assessing potential for dwifery success.

CONCLUSION

As the entire world rapidly moves toward a western medical approach in the management of childbirth, opportunities to consider the human value of traditional midwifery increasingly will become rare. While the dominant society may have failed to recognize the significance of the granny midwife, she has been valued by many childbearing women as an available source of wisdom and experience. Internationally, the World Health Organization recently has recognized the absolute necessity of maintaining the practices of traditional birth attendants. The concerns of the World Health Organization, in fact, are similar to those of some of the interviewed midwives who argued that the needs of childbearing women simply cannot be met by the existing pool of physicians. In fact, one midwife commented, "As long as God is on his throne and God is yet in Alabama, there will be midwives to provide for the poor." Now, however, with less than 1 percent of all births in Alabama being attended by the grannies, the midwives for the most part, have accepted their fates. The acceptance of the death of these age-old practices, however, in no way diminishes the loss; these traditions provided indigenous women with appropriate paradigms for the culturally sensitive management of childbirth for generations.

REFERENCES

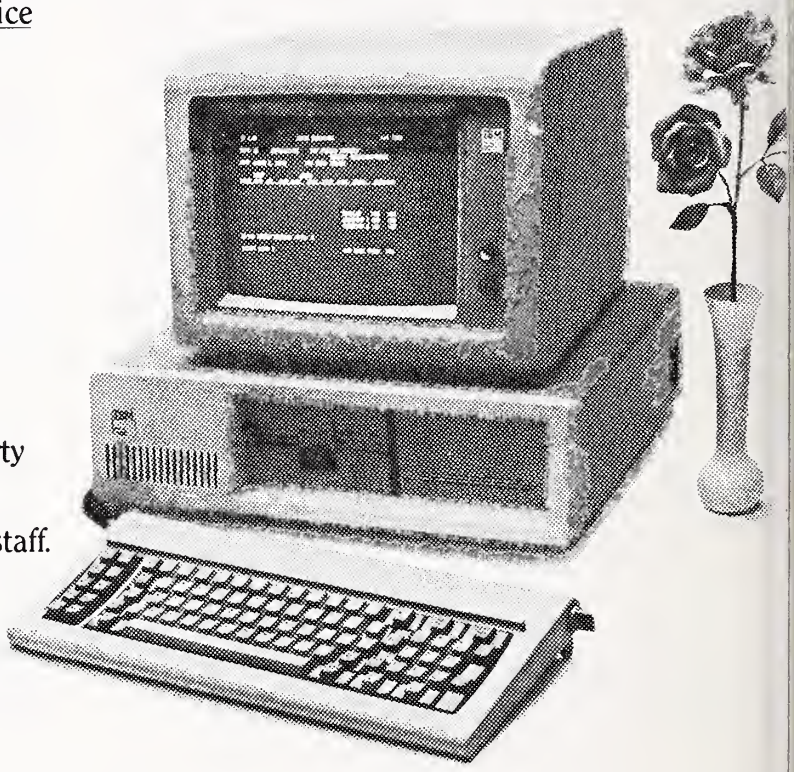
1. Alabama's midwifery problem. *Med Assoc Alabama* 3:148, 1933.
2. Mbiti JS: *African Religions and Philosophy.* New York, NY, 1970, 142-157.
3. Dunn PM: Obstetric delivery today. *Lancet* 1976.
4. Davis L: Use of castor oil for inducing labor in term patients with premature rupture of membranes. Panel, American College of Nurse-Midwives Annual Convention, 1983.

The IBM Personal Computer
A tool for modern times in the Medical Office.

MEDI-SCAN®, an Authorized IBM® Value-Added Dealer for the Personal Computer

Our Comprehensive $8,995.00 MEDI-SCAN In-office Billing And Accounting System Includes:

- The IBM Personal Computer XT with 128K, 10 Megabyte hard disk.
- The IBM Graphics Printer.
- MEDI-SCAN software—customized for your practice, including procedure numbers for state agencies. Generates accounting reports, comprehensive patient statements, insurance and third party forms.
- Optional electronic paperless billing to third party agencies, where applicable.
- Training—Complete in-office training for your staff.
- Support—"HOT-LINE" 800 number for continuous support.



MEDI-SCAN Single Source Support System

MEDI-SCAN'S unique, comprehensive hardware and software maintenance agreement guarantees continuing service and repair, system updates and additional customization, plus in-office training—all from one source. local training consultants and technicians are dedicated to giving you the best possible service.

IBM Personal Computer XTs are in stock in our local warehouses ready to be immediately installed. Over thre hundred physicians are using the MEDI-SCAN System—join them in making the IBM PC-XT "A tool for mod times in the medical office."

Networking available for group practices and clinics

I would like to know more about the MEDI-SCAN System on the IBM Personal Computer XT.

Dr. _____

Address _____

City _____ State _____ Zip _____

Phone (___) _____

Or call: 800-922-1021
In MA: 800-462-1009

Send to: **MEDI-SCAN**
90 Madison Street, Worcester, MA 01608

Authorized Value Add Dealer
Persona Comput

MEDI-SCAN®

Service centers currently in: *New England* · *Mid Atlantic States* · *Mid Western States* · *California* · *Texa*

®MEDI-SCAN is a registered trademark of PAL Assoc. Inc.
PAL Associates is an Authorized IBM Value-Added Dealer for the Personal Computer.
®IBM is a registered trademark of International Business Machines Corporation.

Case Report: Extra-anatomic Bypasses in Aortoenteric Fistulas

C.H. Antinori, M.D., E.H. Kain, M.D., J.A. Kuchler, M.D., V.J. Manuele, M.D., L. Pierucci, Jr., M.D., D.T. Villanueva, M.D., Camden*

This paper describes the management of two patients with unusual aortoenteric fistulas. Both patients were managed successfully by excising the contaminated areas and using extra-anatomic bypass techniques for limb preservation followed by protracted parenteral antibiotic therapy.

Aortoduodenal fistula, after aortic aneurysm resection, occurs in 0.5 to 1 percent of cases.[1] Spontaneous aortoduodenal fistula, a rare complication of abdominal aortic aneurysm, almost always is fatal and, even if the patient survives to undergo aortic resection and grafting, mortality is in the range of 50 percent. Ileocecal fistula is an unusual complication of aortoiliac or aortofemoral grafting. Aortoenteric fistulas can be treated by extra-anatomical bypass grafting in an attempt to avoid placing a prosthesis in an area that is contaminated by bowel contents.

We report our experience with two patients with vascular-enteric fistulas who successfully were treated by extra-anatomic bypass grafting. The first patient developed an ileocecal fistula after an aneurysm resection and the second patient developed a spontaneous aortoduodenal fistula.

CASE REPORT 1

A 78-year-old male had an abdominal aortic aneurysm resected and replaced with a Dacron™ aortoiliac prosthesis at another institution in 1979. He was admitted to Cooper Medical Center in February 1981, with gastrointestinal bleeding. He initially was hemodynamically stable but during a barium enema suddenly developed exsanguinating gastrointestinal hemorrhage and became hypotensive. The patient was taken immediately to the operating room. At surgery, a fistula from the midportion of the right limb of the prosthesis to the cecum was found. The right iliac limb was removed back to the bifurcation and the end oversewn. The native right iliac artery stump was oversewn. The opening in the cecum was closed. The abdominal incision was closed and the patient was taken to the intensive care unit for monitoring and observation of the status of the leg. The leg immediately began to look ischemic; the patient was taken back to the operating room and a femorofemoral bypass graft was performed using a Dacron™ prosthesis (Figures 1 and 2). Postoperatively, he did well. Cultures taken at the operation grew *Enterobacter aerogenes*. He was placed on a one-month course of antibiotics and made an uneventful recovery. On a recent admission to the hospital for a cardiac arrhythmia, he had an excellent pulse in the graft and no signs of infection. He complained of claudication in the leg after walking three blocks.

CASE REPORT 2

A 73-year-old female was admitted to Cooper Medical Center in February 1982. She gave a history of obstipation for a week. The patient was a nonsmoker who had no significant medical or surgical illness in the past.

*From the Department of Surgery, Cooper Hospital/University Medical Center, Camden. Correspondence may be addressed to Dr. Antinori, 455 Route 70 West, Cherry Hill, NJ 08002.

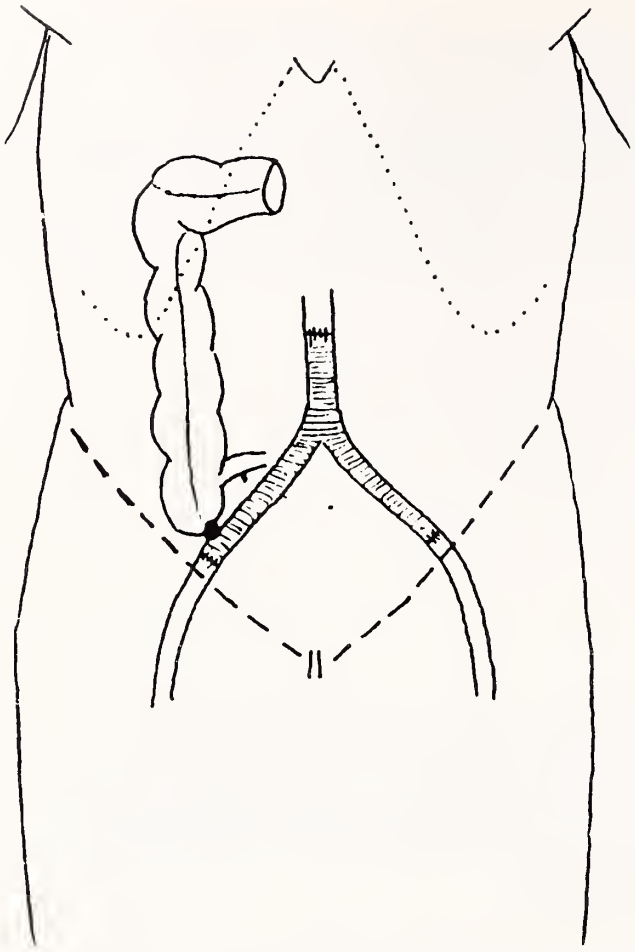


Figure 1—From case report 1, an ileocecal fistula. Illustration by James DellaRusso, M.D.

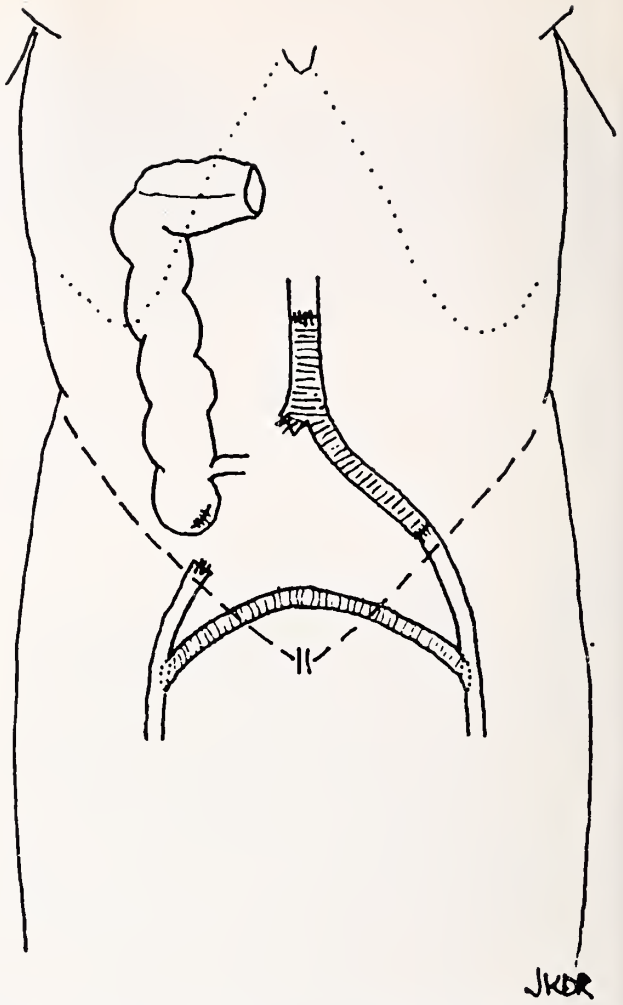


Figure 2—From case report 1, resection of fistula and re construction with femorofemoral bypass. Illustration by James DellaRusso, M.D.

Abdominal examination was remarkable in that no masses were felt in her abdomen, but the examiner felt a fecal impaction in her rectum and thought this was the cause of her problems. Her stool was negative for occult blood but the hemogram revealed: Hgb, 10; Hct, 33; MCV, 91; MCH, 30; and MCHC, 32.7. She had a white count of 10,000 and a normal differential. Her sedimentation rate was elevated and her SMA 12 showed an LDH of 411, SGOT of 256, and alkaline phosphatase of 329. Bilirubin was 1.1 and total protein was 5.9. Her BUN, creatinine, and electrolytes were normal. The patient persistently complained of cramping abdominal pain and therefore an extensive diagnostic evaluation was needed.

Chest and abdominal x-rays and liver-spleen scan were normal. Ultrasound showed a normal gallbladder and pancreas. Barium enema revealed scattered diverticuli, but no other lesions. While the patient was being evaluated, she suddenly developed rapid gastrointestinal bleeding with the passage of large amounts of maroon-colored stool per rectum. Her blood pressure remained 100/70, but her pulse accelerated to 120. Immediate endoscopy revealed a gastric ulcer and what was interpreted to be bleeding from duodenitis. The patient continued to bleed rapidly in spite of intensive medical therapy, and she was taken to the operating room. Although the preoperative diagnosis was upper gastrointestinal bleeding due to peptic ulcer disease, the surgeon found an aortoduodenal fistula with an abdominal aortic aneurysm that measured 4 cm in diameter. The distal aorta and iliacs were oversewn; a lateral closure of the duodenum and a gastroenterostomy to bypass this area were performed. The abdominal incision then was closed and a right axillobifemoral artery bypass graft was performed to the common femoral arteries using a 10 mm Dacron™ prosthesis (Figures 3 and 4). Postoperatively, she remained hemodynamically stable and recovered extremely well. Cultures taken during surgery grew an alpha hemolytic *Streptococcus*. A one-month course of parenteral antibiotic therapy was administered. At the time of discharge, the patient had good pulses in the graft and the extremities felt warm. She has remained well.

DISCUSSION

Aortoenteric fistulas of any etiology are extremely uncommon, but most develop after prosthetic replacement of the abdominal aorta. Spontaneous aortoduodenal fistula is an extremely unusual complication of an abdominal aortic aneurysm. Reckless et al. reviewed the literature up to 1972 and found only 128 cases with 15 patients treated surgically and 5 survivors.[2] Lewis et al. reviewed the literature in 1979 and found 64 cases reported since 1957.[3] Only 28 patients were treated surgically and 14 patients survived. Our patients demonstrated the typical pattern of a "herald bleed" with a "period of grace" prior to the ex-

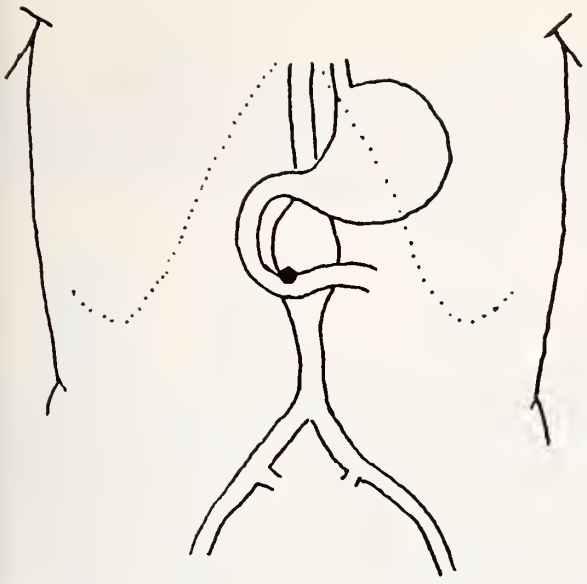


Figure 3—From case report 2, an aortoduodenal fistula. Illustration by James DellaRusso, M.D.

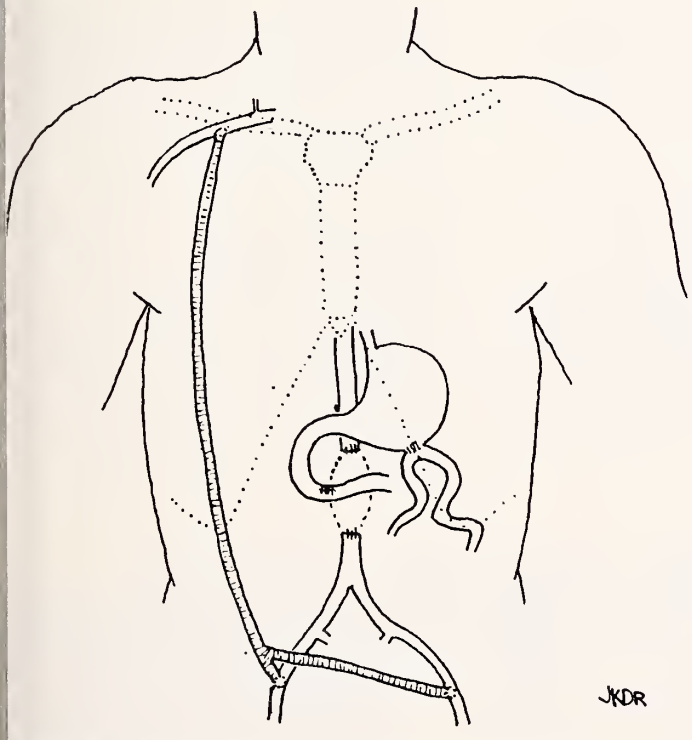


Figure 4—From case report 2, resection of aneurysm and fistula reconstruction with axillobifemoral bypass. Illustration by James DellaRusso, M.D.

anguinating hemorrhage resulting in cardiovascular collapse. The physical examination should reveal the pulsatile abdominal mass, but in our second case, an obese woman with a small aneurysm, the aneurysm was not appreciated by palpation. Abdominal ultrasonography or CT scan focusing on the aorta probably would have demonstrated this aneurysm.

The usual treatment of choice for aortoenteric fistulas is removal of the prosthesis, if possible, and closure of the distal aorta lateral repair of the bowel; and extra-anatomic vascular bypass if necessary. We feel that extra-anatomic bypass is the treatment of choice because of our experience with several patients in whom residual prosthetic material in the contaminated field resulted in late recurrence of infection. This complication proved virtually impossible to treat. Others report similar experiences.[4-6] In our first case, the right iliac limb of the prosthesis was removed all the way up to the bifurcation. This provided a margin of several centimeters away from the fistula. The native distal iliac artery then was oversewn. Thus, there was no prosthetic material left in the contaminated area. In our second case, no prosthetic material was left in the abdomen.

The patency rate for extra-anatomic bypasses, in many series, is similar to that of aortoiliac bypasses. Blaisdell et al. recorded a two-year patency rate of 80 percent with femorofemoral bypasses and 50 percent for axillofemoral bypasses.[6] Johnson's group reported even better results with axillobifemoral bypass grafts; they had a 76 percent five-year patency rate which was similar to their results with aortoiliac bypass, though the extra-anatomic bypasses required more frequent "remedial" surgery to keep them patent.[7] We also have been very satisfied with our extra-anatomic bypasses done in other settings.

SUMMARY

Two unusual cases of vascular-enteric fistulas are presented. Both cases exhibited the typical pattern of a small "herald bleed" followed by a grace period of several days before subsequent exsanguinating hemorrhage. Both patients were treated successfully utilizing the principles of excision of contaminated prosthetic material, extra-anatomic bypass, and long-term antibiotic therapy.

REFERENCES

1. Eastcott HHG: An appraisal of the use and functions of vascular grafts in England, in Sawyer PN, Kaplitt MJ (eds): *Vascular Grafts.* New York, NY, Appleton-Century-Crofts, 1978.

2. Reckless JPD, McColl I, Taylor GW: Aortoenteric fistulas: An uncommon complication of abdominal aortic aneurysms. *Br J Surg* 59:458-460, 1972.

3. Lewis RT, Allan CM: Spontaneous aortoduodenal fistula: Successful treatment by extra-anatomic vascular bypass. *Can J Surg* 22:234-236, 1979.

4. Evans DM, Webster JHH: Spontaneous aortoduodenal fistula. *Br J Surg* 59:368-372, 1972.

5. Elliott JP Jr, Smith RF, Szilagyi DE: Aortoenteric and paraprosthetic-enteric fistulas: Problems of diagnosis and management. *Arch Surg* 108:479, 1974.

6. Holcroft JW, Conti S, Blaisdell FW: Extra-anatomic bypass grafts. *Surg Clin North Am* 59:649-658, 1979.

7. Johnson WC, Logerfo FW, Vollman RW, Corson JD, O'Hara ET, Mannick JA, Nabseth DC: Is axillo-bilateral femoral graft an effective substitute for aortic-bilateral iliac/femoral graft? *Ann Surg* 186:123-129, 1977.

Thinking con

Think

As in Blue Cross of New Jersey. *The* single source for computerization.
☐ Because Medical Management Services from Blue Cross now offers a unique automated office system.
☐ Only Blue Cross offers this unique system, because only Blue Cross has the experience in the health care field (half a century's worth!), the data processing know-how and the claims processing expertise to make it all work efficiently and effectively.

The system itself.

You receive a stand-alone system using IBM or Texas Instruments computers that is physically located in your office. It is operated by your office personnel—they do not have to have any data processing experience—and the system is completely under their control at all times.

The software and system support.

This modular system provides a complete software package for your office which utilizes Blue Cross' expertise in health care financing, automated hospital admission/approval systems, automated claims submission, and leadership in paperless processing. Only Blue Cross can offer the benefits of this wealth of experience and offer single source capability for computerization.

Your people receive full and complete training and ongoing support in system operation. We accept full responsibility for hardware and software maintenance.

What the system does for the physician.

Whether you are an individual or group practice, this system will relieve paperwork...provide fast access to necessary patient information...and give you much more time to tend to the clinical aspects of your practice... and, above all, increase the efficiency of the office and the income of the practice! All from a single source for computerization.

Some of what you get with the System:

- An easy-to-use system.
- Instant access to patient account information by account number.

Take a minute to check this list!

- ☐ Your volume is at least 80 patients per week.
- ☐ Your daily cash control and records keeping procedures need to be improved.
- ☐ Your receivables are greater than 17% of your total annual charges.
- ☐ You are forced to write off more than 5% of your net receivables as uncollectable.
- ☐ You are running behind in your insurance billings and collections.
- ☐ Your service bureau already charges you more than $4,200 per year.
- ☐ You experience a high turnover of clerical employees or need to increase the productivity of your present staff.
- ☐ You find it difficult to get complete and current data on patient treatment patterns, facilities utilization, and services on a regular weekly, monthly and annual basis.
- ☐ Your quarterly and annual payroll reports are now done manually.
- ☐ You have difficulty getting useful management information about your practice when you need it.
- ☐ Your "most current" financial statement for the practice is already out of date.

If you have checked off any of the above, you are a candidate for Medical Management Services.

uterization?

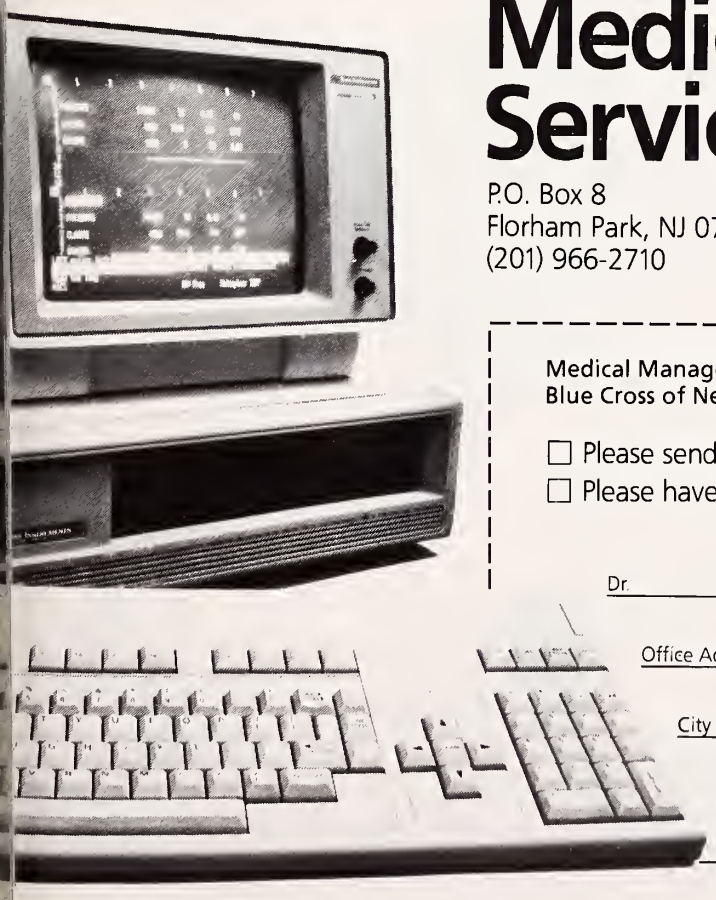
blue✓

- Production of patients' statements on daily, weekly or monthly basis —whichever billing cycle is best for your practice.
- Automatic production of standard insurance (AMA) claim forms.
- A daily charge and collection summary which recaps all daily patient activity.
- An aged accounts receivable trial balance which can be printed on demand.
- Practice productivity reports broken down by procedures and payment classifications (insurance, self-pay, etc.)
- Monthly management reports.
- Medicare payment distribution (20% of co-pay automatically calculated if assignment is accepted).
- Single-date entry for all financial transactions.
- A recall system which prints lists, statistics and "labels."
- Customized reports for special requirements.
- Automatic retention of claims information for rebilling purposes.
- Improvement in cash flow and office efficiency.

Free Office Analysis

Included in the services provided is a free office analysis where a Medical Management Services representative analyzes pertinent data on your current work flow, patient volume, initial set-up for new patients, billing, insurance filing and follow-up. This Office Analysis is a prerequisite for installation and is made at no charge.

Fill out the coupon, or call, for further details and to initiate your Office Analysis.



Medical Management Services

P.O. Box 8
Florham Park, NJ 07932
(201) 966-2710

Blue Cross of New Jersey ®

Medical Management Services
Blue Cross of New Jersey, P.O. Box 8, Florham Park, NJ 07932

☐ Please send me additional information.
☐ Please have a representative call to arrange an Office Analysis.

Dr. _____

Office Address _____

City _____

State/Zip _____ Office telephone _____

® Registered Marks Blue Cross and Blue Shield Association

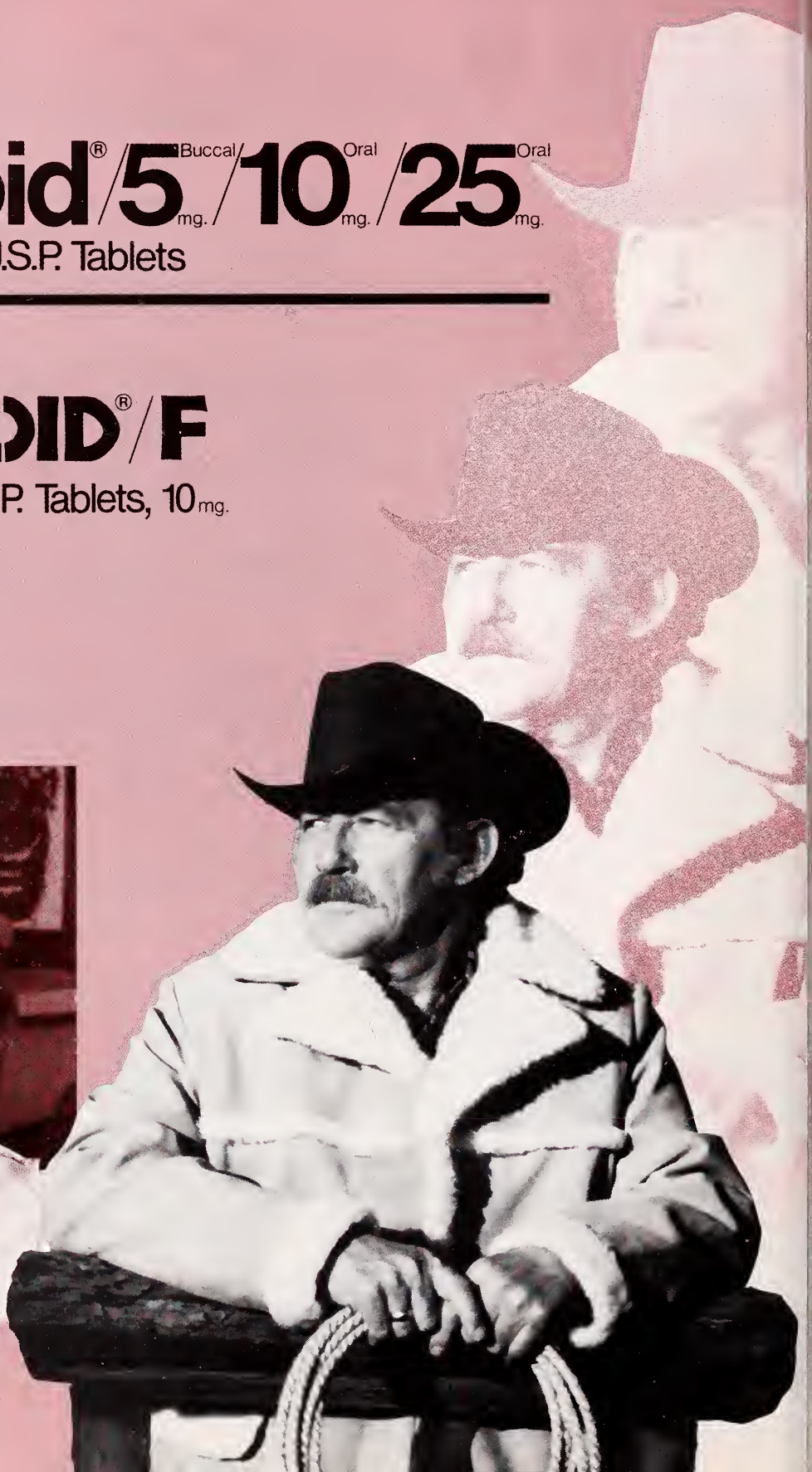
BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android®/5 mg. Buccal/10 mg. Oral/25 mg. Oral
Methyltestosterone U.S.P. Tablets

ANDROID®/F
Fluoxymesterone U.S.P. Tablets, 10 mg.





Case Report: Pancreatic Pseudocyst Associated with Valproic Acid Therapy

Arnold M. Baskies, M.D., Willingboro*

Our patient was treated with anticonvulsant medications including valproic acid. The patient developed gastric outlet obstruction and was diagnosed as having a pancreatic pseudocyst probably secondary to pancreatitis from valproic acid therapy. This is the first report of such a complication possibly due to this medication.

Previously reported side effects of valproic acid (Depakene®) include hematological abnormalities, hepatotoxicity, and pancreatitis.[1,2] This paper presents a previously unreported association of pancreatic pseudocyst with valproic acid therapy.

CASE REPORT

Our patient is a retarded, 19-year-old white male who was hospitalized for evaluation of persistent vomiting, mild hematemesis, weight loss, and abdominal tenderness.

He was the product of a full-term, uncomplicated pregnancy, and developed normally until 18 months of age when he developed *Hemophilus influenzae* meningitis followed by coma for two weeks. Thereafter, he developed psychomotor and minor motor seizures, spastic tetraparesis, and severe mental retardation.

In 1975, at age 14 years, he had generalized tonic-clonic seizures. In 1976, he had 8 tonic-clonic seizures; in 1977, he had 13 tonic-clonic seizures and 254 minor motor seizures. Valproic acid (15 mg/kg) was prescribed in October 1978, and the dose was later increased to 23 mg/kg, resulting in a dramatic reduction in the seizure frequency. In March 1979, he was evaluated at another medical center for aspiration pneumonia, decreased oral intake, vomiting, and a five-pound weight loss. A Stamm gastrostomy was performed. He did well until January 1980, when vomiting recurred. An upper gastrointestinal series and barium enema were normal. He was found to have guaiac positive vomitus and tarry stools. His serum amylase was 91 (normal: 50 to 200). In February 1980, because of persistent vomiting, the patient was admitted for evaluation. His medications on admission consisted of valproic acid 250 mg t.i.d., phenobarbital 30 mg b.i.d., and phenytoin 250 mg/day. Examination revealed epigastric fullness. A repeat upper gastrointestinal series revealed a markedly effaced stomach displaced anteriorly; the duodenal loop was displaced to the right. A sonogram showed a large pancreatic pseudocyst with a normal gallbladder. Laboratory studies included serum calcium level of 8.9 mg/dl, normal liver function tests, and valproic acid levels ranging between 27 and 5.3 mg/dl (therapeutic 5 to 10 mg/dl).

At surgery, a large retrogastric pseudocyst, with a thick, mature wall, densely adherent to the posterior gastric wall was found. The pseudocyst contained 800 ml of murky, greyish fluid and necrotic material. Palpation of the gallbladder revealed no stones. A cystogastrostomy was performed and the patient recovered uneventfully. He has been asymptomatic.

*From Zurbrugg Memorial Hospital where Dr. Baskies is affiliated with the Department of Surgery. Correspondence may be addressed to Dr. Baskies, Zurbrugg Memorial Hospital, Rancocas Valley Division, Willingboro, NJ 08046.

DISCUSSION

Valproic acid is an oral anticonvulsant; structurally, it is a short-chain fatty acid which is unrelated chemically to other anticonvulsant agents. It is used adjunctively for simple or complex absence seizures and for patients with multiple seizure types which include absence spells.

When compared to other anticonvulsants, adverse reactions are few. Among the more common side effects are nausea, vomiting, colic, and diarrhea; anorexia and increased appetite may occur. Alopecia, rashes, headaches, insomnia, sedation, excitation, and behavorial changes have been observed. More serious reactions include hepatotoxicity, thrombocytopenia, inhibition of platelet aggregation, and decreases in fibrinogen levels.

A literature review reveals reports of three patients with pancreatitis associated with valproic acid therapy.[1,2] To the best of our knowledge, our case is the first report of a possible association between valproic acid therapy and pancreatic pseudocyst formation. Absence of other causes for pseudocyst formation in this patient makes it likely that valproic acid was responsible for the development of the pseudocyst.

The three previously described cases of pancreatitis and our case of a pancreatic pseudocyst, which presumably was a sequel to undiagnosed pancreatitis, emphasize the need for monitoring pancreatic function in patients receiving valproic acid. Such monitoring would appear to be indicated especially where gastrointestinal signs and symptoms are present. When a pseudocyst is present, the serum amylase may be normal,[6] as was the case in our patient, but a 24-hour amylase clearance determination and an abdominal ultrasound may help establish the diagnosis.[3-5]

Physicians who prescribe valproic acid should be aware of possible pancreatic damage as a result of this therapy and should confirm and treat this problem promptly.

REFERENCES

1. Batalden P, VanDyne BJ, Lloyd J: Pancreatitis associated with valproic acid therapy. *Pediatrics* 64: 520-522, 1979.
2. Canfield PR, Bagnessl P, Camfield CS, Tibbles JA: Pancreatitis due to valproic acid. *Lancet* 1:1198-1199, 1979.
3. Cooney DR, Grosfeld JL: Operative management of pancreatic pseudocysts in infants and children: A review of 75 cases. *Ann Surg* 182:590-596, 1975.
4. Rose JS, Becher JH, Staiano SJ, Campos E: Proceedings: B-mode sonographic evaluation of abdominal masses in the pediatric patient. *Am J Roentgenol Radium Ther Nucl Med* 120:691, 1974.
5. Owens BJ, Hamit HF: Pancreatic abscess and pseudocyst. *Arch Surg* 112:42-45, 1977.
6. Wood RAB, Moossa AR, Blackstone MO, Bowie J, Collins P, Lu CT: Comparative value of four methods of investigating the pancreas. *Surgery* 80:518-522, 1976.

1. Payment to physicians is based on the fee for service principle—not on a flat retainer (capitation).
2. HealthWays helps to safeguard the concept of private practice in this ever increasing competitive environment.
3. Personal Physicians (Internists, Family & General Practitioners, Pediatricians, Obstetricians/ Gynecologists) manage patient care and work with specialists ensuring proper and consistent treatment.
4. Physicians set the standards for medical care, not actuaries or computers.
5. Your high quality care level is maintained.
6. HealthWays covers an extensive range of services for its members including periodic routine physical examinations and other preventive care.

10 significant reasons why over 700 physicians now participate in HealthWays–the health care management company.

7. Through HealthWays, you are able to provide care in the most appropriate setting.
8. HealthWays is there as a resource to help you coordinate patient care.
9. HealthWays pays its physicians' claims promptly. With HealthWays, there is no bad debt.
10. It is important to us at HealthWays to maintain an open dialogue with our participating physicians at all times. Our Health Services Department is readily available to provide assistance to you and your staff.

In these changing times, look to HealthWays, the organization that works with physicians. We know you will find it to be a superior answer for your practice and your patients.

For further information, call Jon Marsicano, M.D., Vice President, Medical Affairs at 800-223-0812.

Abary, Antonio V., M.D.
Abary, Raquel R., M.D.
Abbott, Charles P., M.D.
Abouchedid, Claude, M.D.
Abrams, Jerome, M.D.
Abud, Alfredo R., M.D.
Abud, Arlel F., M.D.
Agran, Marvin R., M.D.
Ahmad, Imtiaz, M.D.
Ahmad, S. Mubashar, M.D.
Ahmad, Sarfaraz, M.D.
Ahmad, Syed S., M.D.
Ahmadl, David F., M.D.
Ainslie, William H., M.D.
Ainslie, William H., Jr., M.D.
Aitken, Gerard J., Jr., M.D.
Akawie, Richard S., M.D.
Alcasid, B. I., M.D.
Alexander, Raymond T., M.D.
Allgair, William A., M.D.
Alvarez, Reinaldo G., M.D.
Ambrosio, Severino J., M.D.
Amendo, M.T., M.D.
Amorosa, Judith, M.D.
Arlen, Harold, M.D.
Aruna, Pasalai N., M.D.
Asbel, Donald E., D.O.
Athanas, Efthimios, M.D.

Babar, Abdul H., M.D.
Babar, Mumtaz J., M.D.
Baiser, Dennis M., M.D.
Bakhos, Abdel M., M.D.
Balinski,Thaddeus A., M.D.
Ball, Richard M., M.D.
Bancila, Alexandru, M.D.
Bang, Byung-Kee, M.D.
Baril, Carlo T., M.D.
Barofsky, Norman, M.D.
Baron, Stuart, D.O.
Battin, Keith G., M.D.
Beams, Michael E., D.O.
Beauchamp, David T., M.D.
Bedi, Harjinder S., M.D.
Beggs, James L., M.D.
Behman, Mankarios S., M.D.
Belafsky, Henry A., M.D.
Belkoff, M. Michael, D.O.
Berkow, Bori, M.D.
Berkow, Lester H., M.D.
Blackman, Edward L., M.D.
Blondo, Dennis L., M.D.
Bloom, Herbert, M.D.
Blum, Richard H., M.D.
Bogart, Walter B., M.D.
Boodin, Bernard B., M.D.
Boogdanian, Victor H., M.D.
Borow, Maxwell, M.D.
Borrus, Joseph C., M.D.
Borsky, Martin, M.D.
Botwin, Clifford A., D.O.
Boyd, Robert D., D.O.
Boylan, Joseph I., Jr., M.D.
Brady, Edward A., M.D.
Brandwein, Charles J., M.D.
Branon, Mark E., M.D.
Braun, Alan P., M.D.
Brenna, Joseph D., M.D.
Brennan, George G., M.D.
Bretones, Reynaldo, M.D.
Brickman, Anthony, M.D.
Brickner, Gary R., M.D.
Brinen, Steven G., D.O.
Brodman, Richard R., M.D.
Brody, Herbert S., M.D.
Bromberg, Fred G., M.D.
Bronstein, Milton R., M.D.
Buck, Warren G., M.D.
Bucolo, Salvatore, M.D.
Bukosky, Richard J., M.D.
Bunales, Lilia F., M.D.
Bunin, Sara Ann, M.D.
Burks, William P., M.D.
Buzard,Thomas A., M.D.
Byahatti, Veerappa G., M.D.

Cabrera, Roy C., M.D.
Caldora, John B., M.D.
Campos, Humberto, M.D.
Cannamela, Vincent J., M.D.
Capitly, Domiciano V., M.D.
Capotosta, Thomas J., M.D.
Carabelli, A. Albert, M.D.
Carabuena, Ramon, M.D.
Cardinale, Robert, M.D.
Carlson, Lennart A., M.D.
Carney, Alexander S., M.D.
Carroll, Bruce J., M.D.
Chaise, Laurence S., M.D.
Chandler, James J., M.D.
Chaudhery, Shaukat, A., M.D.
Chen, Michael T., M.D.
Childers, Eugene L., M.D.
Chimene, Donald R., M.D.
Chinitz, Jack, M.D.
Cho, Chang C., M.D.
Cho, Kun H., M.D.
Cho, Kyung Ho, M.D.
Cho, Seung Chun, M.D.
Chodosh, Bruce T., M.D.
Choi, Soon C., M.D.
Choi, Stan S., M.D.
Chowdhury, Bhanwar, M.D.
Chuirco, Anthony A., M.D.
Chung, Uei K., M.D.
Ciencewicki, Michael P., M.D.
Cipolla, Joseph A., M.D.
Clair, Frank A., Jr., M.D.
Clark, Charles G., M.D.
Clarke, Francis M., Jr., M.D.
Co, Antonio, M.D.
Cohen, Allan B., M.D.
Cohen, Barry H., M.D.
Cohen, Richard I., M.D.
Cohen, Seymour, M.D.
Collins, Harry, M.D.
Constandis, Decebal D., M.D.
Copleman, Hyman B., M.D.
Costanzo, Patricia A., M.D.
Cottone, F. John, M.D.
Cottone, Robert N., M.D.
Cowen, Bruce R., M.D.
Crowley, J. Gerard, M.D.
Cunningham, William F., M.D.
Curtis, Paul, M.D.

Dalal, Vasant V., M.D.
D'Ambola, Samuel F., M.D.
Daubert, James J., M.D.
Davidson, J. Thomas, M.D.
DeAngelis, Eugene F., M.D.
deBlois, F. Gerry, D.O.
deBlois, J. Albert, M.D.
DeBorja, C.E., Jr., M.D.
DeCastro, Leticia V., M.D.
DeFrancesco, J.C., M.D.
Derman, Arnold, M.D.
DeSandre, Louis A., M.D.
DeSandre, Richard, M.D.
DeSantis, Joseph A., M.D.
Desmond, Thomas E., M.D.
DiBlanco, John, M.D.
Diemer, Louis M., III, M.D.
Dietzel, Herbert A., M.D.
Donatelli, Anthony, A., M.D.
Dooley, Charles E., Jr., M.D.
Doyle, Alden J., M.D.
Dubash, Dara B., M.D.
Dwyer, John T., M.D.
Dy, Ceferino T., M.D.

Eibschutz, Ghitta, M.D.
Einhorn, Robert, M.D.
Elber, Daniel A., D.O.
Elkind, Barry, M.D.
Epstein, Stefan E., M.D.
Erdman, William, M.D.
Errgong, William H., M.D.
Ezon, Frederick C., M.D.

Fares, Louis G., M.D.
Fasulo, Alexander, M.D.
Fein, Harold B., M.D.
Feinsmith, Burton M., M.D.
Feit, Lawrence J., M.D.
Felton, Stephen M., M.D.
Ferges, Mitchell L., M.D.
Ferrante, John W., M.D.
Fidler, W. Larch, III, M.D.
Finkel, Jerrold S., M.D.
Fiorelli, Richard C., M.D.
Fishkoff, Daniel, M.D.
Fishman, Louis, M.D.
Fleisch, Charles M., D.O.
Flores, Belen P., M.D.
Flores, Eduardo G., M.D.
Flynn, Joan R., M.D.
Formica, Palma E., M.D.
Fox, Howard D., D.O.
Fox, Milton D., M.D.
Fox, Richard L., M.D.
Frank, Steven A., M.D.
Franzese, Neil C., M.D.
Franzoni, John D., M.D.
Franzoni, Karl T., M.D.
Freeman, Elliot, M.D.
Freis, Peter C., M.D.
Freyne, James K., M.D.
Fried, Erica O., M.D.
Friedman, Mark, M.D.
Friedman, Marvin, D., M.D.
Frimmer, Daniel, M.D.
Frohman, Bertram H., M.D.

Gamao, Eddie M., M.D.
Gelbard, Hyman, M.D.
Gelber, Robert D., M.D.
Geller, Toby A., M.D.
Gerard, Franklyn P., M.D.
Gersch, Marvin J., M.D.
Gjenvick, Timothy C., M.D.
Glasgold, Alvin I., M.D.
Glasser, Benjamin F., M.D.
Glick, Ronald S., M.D.
Godrey, Francis J., M.D.
Goldberg, Paul E., M.D.
Goldenberg, David A., M.D.
Goldman, Marvin, M.D.
Goldman, Richard H., M.D.
Goldsmith, Joel W., M.D.
Goldson, Howard, J., M.D.
Goldstein, Morton H., M.D.
Gomez, Rene, M.D.
Gonnella, Gino R., M.D.
Gordon, Richard D., M.D.
Gorelli, Giuliano, M.D.
Gottlieb, Stanley, M.D.
Gould, Louis F., M.D.
Grabelle, Howard A., M.D.
Green, Philip S., M.D.
Green, Stuart N., M.D.
Greenberg, William B., M.D.
Greenwald, Alfred E., M.D.
Gregoria-Tena, Rosita, M.D.
Gross, Steven C., M.D.
Grubman, Jerold, M.D.
Guha, Hirak, M.D.

Haas, Alexander Z., M.D.
Haas, Roger C., M.D.
Haberman, Stanley J., M.D.
Hafitz, George, M.D.
Hafitz, Julius J., M.D.
Halivopoulos, E. M.D.
Halpern, Ilan Z., M.D.
Hammond, Betty, M.D.
Haque, Mohammed W., M.D.
Hardy, Geza Robert, M.D.
Harlin, Joyce A., M.D.
Harris, Joseph T., M.D.
Hastings, James B., M.D.
Heeg, Michael M., M.D.
Hefler, Stephen E., M.D.
Herman, Jeffrey P., M.D.
Herschman, Alan, M.D.
Hindawi, Ruhi K., M.D.
Hirsch, Leonard M., M.D.
Hochron, Stuart M., M.D.
Hodes, Steven E., M.D.
Homer, Leroy, M.D.
Horrigan, W. Donald, M.D.
Hoyos, Fernando, M.D.
Hsia, Wellington, M.D.
Hsu, Shih-Piao, M.D.
Hunninghake, Leroy H., M.D.
Huq, Irfan-Ul, M.D.
Hutchison, Dwight C., M.D.

Immordino, John A., M.D.
Ingram, Willard J., M.D.
Ioffreda, Pasquelino F., M.D.
Iqbal, Riaz, M.D.
Isaacson, Frederick M., M.D.

Jacobs, Ivan H., M.D.
Jacoby, Glenn, M.D.
Jasnionowski, E.A., M.D.
Jerrold, S. Harrison, M.D.
Jolley, Michael N., M.D.
Josell, Edward, D.O.
Joselson, Howard Z., M.D.
Joseph, Anita, M.D.
Julia, Walter, M.D.
Kaczala, O. And
Kahn, Steven P.
Kalko, Charles
Kaminker, Kenn
Kampel, Lewis
Kangos, John
Kaplan, Leopol
Kaplan, Murray
Karbaslan, A.
Karfopoulos, A
Kasoff, Ira, M.D
Kassouf, Edmo
Katz, Melvin I.,
Kauff, Philip L.
Kaye, Susan T.
Keating, Garret
Keene, Robert
Kelberg, Berna
Keller, Malvin S
Kern, Howard
Khan, Majid, K.
Khanna, Santo
Kim, Hyung G.,
Kinateder, Ron
Kingsley, Davic
Kirchner, Richa
Kirshner, Jacob
Klein, Robert L
Kline, Donald,
Kolber, Ronald
Koons, Lawren
Kopidakis, E.G
Korkor, Ralph E
Kososky, Charl
Kostrzewa, R.M
Kothari, Grace
Kothari, Nayan
Kotler, Stuart M
Kovacs, Alexar
Kratzman, E. A
Krauser, Paula
Krausz, Adrien
Kravet, Alvin,
Kreitzer, Micha
Krishnan, R.G.
Kuhn, William
Kumar, Ashok,
Kurman, Micha
Kustrup, John

LaBosco, Loui
LaFalce, Antho
Lang, Richard
Langdon, Doug
Lanza, Raymor
Lasky, Mark L.,
Lathrop, Fred W
Latif, Pervaize,
Laub, Edward
Laudonio, Frar
Lauton, Barry,
Lavine, Ferne
Lazorek, Micha
Leavey, Richar
Lebovitz, Philip
Lee, Chang H.,
Lee, Dae Woo,
Lee, Young I.,
Leff, Charles A
Leff, Stuart J.,
Leiman, Sherw

© 1983 HealthWays Inc.

afael, M.D.
bert S., M.D.
lph J., M.D.
dney B., M.D.
n, J.A., III, M.D.
anna W., M.D.
ncis B., M.D.
Harris C., M.D.
K., M.D.
el R., M.D.
ed S., M.D.
, M.D.
ene J., M.D.
M.D.
., M.D.
ephen M., M.D.
s, James N., M.D.
Theodore, M.D.
)ominick T., M.D.
nan L., M.D.
uncheria, M.D.
lardino, M.D.
Michael, M.D.

ement A., M.D.
lohn S., Jr., M.D.
n, Zenaida A., M.D.
, Pavani, M.D.
Donna D., M.D.
sil S., M.D.
dan, M., M.D.
larc I., M.D.
lid M., M.D.
, George M., M.D.
deric J., M.D.
ilip J., D.O.
anley S., M.D.
Ira E., M.D.
, Jon, M.D.
Leo, M.D.
none, Angelo, M.D.
bert S., D.O.
gin V., M.D.
S., D.O.
homas O., M.D.
, Donald F., M.D.
Frederick J., M.D.
Daniel P., Jr., M.D.
rancis D., M.D.
, John E., IV, M.D.
J., M.D.
raham, M.D.
atthew, M.D.
urice S., M.D.
ngelo J., M.D.
ard H., M.D.
ary J., M.D.
is, M.D.
Richard, D.O.
atu, M.D.
a M., M.D.
Daniel N., M.D.
o, Rufino D., M.D.
seph L., Jr., M.D.
o, Michael A., M.D.
oger V., M.D.
dul W., M.D.
liam F., M.D.

l, M.D.
Narayanan, M.D.

Needell, Gary S., M.D.
Neumaier, George J., M.D.
Newman, Richard, M.D.
Nicora, Bernard J., M.D.
Niemiera, Alexander K., M.D.
Nisar, Mohammed M., M.D.
Nishitani, Noboru, M.D.
Noronha, Joaquim L., M.D.
Nosher, John L., M.D.
Nozick, Jerome H., M.D.
Null, Robert H., M.D.

Obaray, Akbar H., M.D.
Ocken, Paul R., M.D.
Oh, Youn K., M.D.
Oliver, Lawrence H., M.D.
O'Neill, Earl A., M.D.
Ongsiako, Rodolfo G., M.D.
Orenstein, David H., M.D.
Osborne, Alan W., M.D.
Oshin, David R., M.D.
Ostrowski, Edward J., M.D.

Packer, Stuart H., M.D.
Paglia, Ludwig R., M.D.
Pallini, Carlo A., M.D.
Palmieri, Alphonse P., M.D.
Palmieri, Frederick, Jr., M.D.
Palsky, Glenn S., M.D.
Pancer, Bernard, M.D.
Pandya, H.D., M.D.
Panzer, Edward I., M.D.
Pappas, Constantine, M.D.
Paraskevas, Angelos L., M.D.
Parikh, Sheela N., M.D.
Parikh, Sudhir M., M.D.
Park, Young Ho, M.D.
Parker, Martin I., M.D.
Passannante, A.J., M.D.
Patel, Daksh B., M.D.
Patel, Ishvarlal U., M.D.
Patel, Natverlal M., M.D.
Patel, Sushila B., M.D.
Pecora, John J., M.D.
Pellicane, Joanne E., M.D.
Perillo, Louis A., M.D.
Perkoff, Morton, M.D.
Piazza, Gary G., D.O.
Pica, Vincent B., M.D.
Pickens, Robert L., M.D.
Piezas, Mabini, C., M.D.
Pirog, Eugene P., M.D.
Pironti, Pascal A., M.D.
Pizzi, Francis J., M.D.
Platt, Marvin, M.D.
Posta, Alan G., M.D.
Potash, Ronald J., M.D.
Prasad, Rajendra G., M.D.
Prepon, Michael A., M.D.
Press, Lorin R., M.D.
Prodromo, Paul E., M.D.
Proshan, Neil, M.D.
Puchner, Gerhard, M.D.
Pumo, Jerome, Jr., D.O.
Puri, Kamal, M.D.

Rahill, William Joseph, M.D.
Raja, Malayandi, M.D.
Rao, Vatsala V., M.D.
Raza, Mohammad A., M.D.
Reddy, Chenna G., M.D.
Reissman, David I., M.D.
Rezvan, Masoud, M.D.
Robbins, Joseph A., D.O.
Roberts, Dudley A., M.D.
Roberts, R. Michael, M.D.
Rogers, John C., M.D.
Rogow, Louis M., M.D.
Romano, Frank R., M.D.
Roowala, Shabbir H., M.D.
Roque, Celia G., M.D.
Rosen, Alex, M.D.
Rosenbaum, Jeffrey M., M.D.
Rosenberg, Stanley E., M.D.
Rosenblum, Howard W., M.D.
Rosenfeld, David L., M.D.
Rosenman, Howard D., M.D.
Rosenstein, Martin J., M.D.
Rosenthal, Steven, M.D.
Rosner, Bruce P., M.D.
Rossy, William H., M.D.
Roth, Arthur L., M.D.
Rothfarb, Steven H., M.D.
Rothfleisch, Sheldon, M.D.
Rubenstein, Laurence, D.O.
Rubin, Jack D., M.D.
Rubin, Marc R., M.D.
Rubin, William, M.D.
Ruderman, Armand L., M.D.
Rudnitzky, Elliot M., M.D.
Rushnak, Michael J., M.D.
Russell-Brown, Karl E., M.D.

Sabety, Adrian M., M.D.
Safdar, Feroz, M.D.
Safer, Jan N., M.D.
Saini, Balwant S., M.D.
Sakson, John A., M.D.
Saladino, Joseph R., M.D.
Saleem, Mohammed R., M.D.
Saltstein, Elliott, M.D.
Salvati, Carl A., M.D.
Sand, Harold A., M.D.
Santiago, Alectis R., M.D.
Santiago, R. Nito, M.D.
Santoro, Anthony F., M.D.
Santoro, Edgar V., M.D.
Santucci, Frank P., M.D.
Sarkanich, Natalie L., M.D.
Sarkaria, Jasbir S., M.D.
Sarraf, Mohammad A., M.D.
Sass, D.K., M.D.
Sawhney, Om P., M.D.
Sawhney, Veena K., M.D.
Scharf, Jeffrey I., M.D.
Schinco, Frank P., M.D.
Schlesinger, Richard S., M.D.
Schnall, Stanley J., M.D.
Schneider, Samuel, M.D.
Schnur, Bernard M., M.D.
Schoicket, Daniel P., M.D.
Schoss, Maximillian, M.D.
Schottenfeld, Mark A., M.D.
Schriever, Henry G., M.D.
Schulman, Melvin L., M.D.
Schwartz, Louis E., M.D.
Schwartz, Milton D., M.D.
Sckalor, Martin, M.D.
Scully, John T., M.D.
Seed, John C., M.D.
Segarra, Michael, M.D.
Seitzman, Lawrence A., M.D.
Sergeant, John H., M.D.
Shadiack, E.C., Jr., D.O.
Shafi, Mohammad, M.D.
Shah, Ramakant J., M.D.
Shah, Suresh N., M.D.
Shah, Syed G., M.D.
Shangold, Jack E., M.D.
Shapiro, Robert S., M.D.
Sharett, Terrence E., M.D.
Sharim, Iradj, M.D.
Sharlin, David N., D.O.
Sharma, Madho K., M.D.
Sharrett, Richard H., M.D.
Sheehy, Martin J., M.D.
Sheldon, Ira, D.O.
Sherwood, Edward S., M.D.
Shugar, Ronald A., M.D.
Sicherman, Harlan J., M.D.
Silverman, Leon, M.D.
Silverman, Samuel H., M.D.
Silverstein, Michael L., M.D.
Simpson, Alec N., M.D.
Sinha, Gopal K., M.D.
Sisler, Glenn E., M.D.
Sklar, Samuel, M.D.
Skobel, Barry, M.D.
Skvara, Frederick C., M.D.
Slobodien, Howard D., M.D.
Smith, Charles I., M.D.
Smith, J. Michael, M.D.
Smith, Sydney F., M.D.
Smith, Theresa Ann, M.D.
Snope, Frank C., M.D.
Solanki, Indukumar M., M.D.
Solomon, Robert B., M.D.
Somerstein, Michael L., M.D.
Soriano, Bruce V., M.D.
Soriano, Carlos C., M.D.
Soriano, Myrna L., M.D.
Sorvino, A. Ronald, M.D.
Speiden, Lois M., M.D.
Spierer, Robert, M.D.
Spiler, Ira J., M.D
Sprowls, John J., M.D.
Stabile, John R., M.D.
Stahl, Martin B., M.D.
Stahl, Theodore J., M.D.
Stein, Elliott M., M.D.
Stern, Alan G., M.D.
Steward, Robert E., M.D.
Subramoni, V., M.D.
Sullivan, Bessie M., M.D.
Surowiec, Barbara, M.D.
Sweberg, Warren A., M.D.
Swee, David E., M.D.
Sweeney, William A., M.D.

Tabachnick, John F., M.D.
Taboada, Javier G., M.D.
Tallia, Alfred F., M.D.
Tan, Fiorello I., M.D.
Tan, Roland P., M.D.
Tena, Leoncio B., M.D.
Terry, Bernard, M.D.
Thirugnanam, S., M.D.
Tiedemann, Richard N., M.D.
Tokar, Elliot S., M.D.
Tong, Yeow Ching, M.D.
Trachtenberg, E.B., M.D.
Tuma, Victor B., M.D.
Turkish, Sheldon C., M.D.
Tyrrell, Eugene J., M.D.
Uray, Maria N., M.D.
Uray, Tacettin M., M.D.

Vafai, Armine, M.D.
Valencia, Linda O., M.D.
Valencia, Rogelio R., M.D.
Valenzuela, Albert P., M.D.
Van Horn, Paul E., M.D.
Verdoni, John A., M.D.
Vine, Sherwood, M.D.
Viswanathan, Uma M., M.D.

Wadle, Rudi O., D.O.
Wald, Franklin D., M.D.
Waleson, Max, M.D.
Wang, Ching Jen, M.D.
Warfield, William S., M.D.
Warner, Errol, M.D.
Warren, Bertram, M.D.
Warren, Stephen, M.D.
Waskow, Walter H., M.D.
Weber, Charles M., M.D.
Weinberger, George I., M.D.
Weingarten, Michael C., M.D.
Weinstein, Rita, M.D.
Weisenreider, John, M.D.
Weiser, Paul J., M.D.
Weisfogel, Gerard M., M.D.
Weissman, Kenneth, M.D.
Weissman, Murray H. M.D.
Weitzman, Robert H., M.D.
Welt, Howard, M.D.
White, John J., Jr., M.D.
White, Sanford F., M.D.
Wiener, Howard E., M.D.
Wijaya, K.D. Henry, M.D.
Willard, David A., M.D.
Williams, David M., M.D.
Williams, Manley C., M.D.
Williams, Paul T., M.D.
Willis, Elliott H., D.O.
Winant, John G., Jr., M.D
Wininger, Jon G., M.D.
Wittenborn, W.F., Jr., M.D.
Wolansky, Jacob, M.D.
Wong, J.C., M.D.
Wong, Michael Y., M.D.
Worth, David A., M.D.
Wosnitzer, Morey, M.D.
Wozniak, Ronald F., M.D.
Wu, Hen-Vai, M.D.

Yarian, David L., M.D.
Yatrakis, Nicholas D., M.D.
Yood, Harold S., M.D.
Young, Alan, M.D.
Yu, Micky U., M.D.

Zablocki, Lisa R., M.D.
Zadeh, Moloud A., M.D.
Zicherman, Barry, M.D.
Zimmerman, Stanley R., M.D.
Zingarini, Mario L., M.D.
Zoba, Tim C., M.D.
Zobel, George J., D.O.
Zubair, Mohammed, M.D.
Zullo, Joseph C., M.D
Zullo, Robert J., M.D
Zutz, Harry M., M.D.
Zykorie, David, M.D.

HealthWays
THE WAY TO BETTER HEALTH CARE.
HEALTHWAYS INC. • PARKWAY TOWERS
485 U.S. ROUTE 1 • ISELIN, NJ 08830
800-223-0812.

Case Report: Familial Dysalbuminemic Hyperthyroxinemia—A Variant

Michael H. Goldman, M.D., and Karl Klinges, M.D., Englewood*

Elevated T_4 levels seen in familial dysalbuminemic hyperthyroxinemia may mistakenly suggest hyperthyroidism. An elevated uptake and scan seen in the patient presented further confused the true euthyroid state.

Familial dysalbuminemic hyperthyroxinemia (FDH) recently was described in patients with an elevated T_4 level and an elevated Free Thyroxine Index, but showing a clinically euthyroid state.[1-6] Confirming this normal thyroid status is a normal T_3 RIA, a normal thyroid stimulating hormone (TSH) response to thyroid releasing hormone (TRH), and a normal thyroid uptake of iodine. In our case report, a patient with FDH is described who further confuses the overlap in laboratory differentiation of T_4 excess states by having an elevated uptake and scan.

CASE REPORT

Our patient was a 22-year-old white female referred for consultation due to a high T_4 level. She gave no history of hyperthyroid symptomatology. Her past medical history was unremarkable and there was no family history of thyroid disease. She recently was evaluated for secondary amenorrhea but presently menstruates every 40 days. Physical examination confirmed a euthyroid state and the thyroid was judged to be normal. No ophthalmopathy was noted. (Table)

A six-hour I-123 thyroid scan and uptake revealed a slightly enlarged gland with an elevated uptake 18.6 percent (normal 13 percent).

Because of the patient's clinical euthyroid state, normal T_3 RIA, and TRH stimulation test, no therapy was felt to be indicated.

A brother of the patient who was unable to be eval ated had the following laboratory data: T_3 RIA 16 (normal: 110 to 235 ng/dl), T_4 RIA 17.6 (normal: 5 12 mcg/dl), T_3 RU 45 (normal: 35 to 45%), Free T_4 1 (normal: 1 to 2.3 ng/dl). He reportedly shows no sig or symptoms of hyperthyroidism.

DISCUSSION

Hyperthyroxinemia does not always mean hype thyroidism. Elevated thyroid binding globulin (TBG peripheral resistance to thyroid hormone, and a r cently described condition called familial dy albuminemic hyperthyroxinemia (FDH) can increa T_4 levels without causing a clinical thyroid exce state.[1-9] Increased TBG reflects an increased binding T_4 to its protein and the T_3 Resin Uptake usually depressed giving a normal Free Thyroxine Index (FT In resistant states the FTI is elevated, but the thyroi stimulating hormone (TSH) inappropriately is i creased reflecting an insensitivity to circulatin thyroid hormone. In FDH, the FTI is increased becau of the abnormal excessive binding of T_4 to albumi which then is measured along with the T_4 bound TBG and prealbumin. This patient's albumin bindi

*From Englewood Hospital, where Dr. Goldman is Attendin Department of Medicine, and Dr. Klinges is Attending, D partment of Obstetrics-Gynecology. Correspondence may addressed to Dr. Goldman, 600 Palisade Avenue, Englewo Cliffs, NJ 07632.

TABLE

Laboratory Report

Laboratory Tests	Patient	Normal
T_4	19, 17, 23, 23 mcg/dl	5 to 12 mcg/dl
T_3, RIA	157 ng/dl	110 to 230 ng/dl
T_3 RU	39, 45%	35 to 45%
(Baseline) TSH	4, 2 MIU/ml	<7 MIU/ml
(Post TRH) TSH	18 MIU/ml	12 to 32 MIU/ml
Free T_4	2.1 (x2) 2.8, 2.3 ng/dl	1 to 2.3 ng/dl
LH	14 MIU/ml	6 to 30 MIU/ml
FSH	5 MIU/ml	4 to 30 MIU/ml
Prolactin	30, 15 ng/ml	<22 ng/ml
TBG	22 mcg/ml	12 to 28 mcg/ml

*Electrophoresis of T_4 I-125 Binding**

Laboratory Tests	Patient	Control
TBG	40.7%	60.3%
Albumin	41.2%	7.4%
TBPA (Thyroid-binding Prealbumin)	18.0%	33.0%

*Courtesy of Dr. Ingbar, Thorndike Laboratory, Harvard Medical School.

as nearly six times normal. In contrast to patients ith hyperthyroidism, persons with FDH have a nor- al T_3 RIA and a normal TSH response to TRH. In reviously reported FDH cases, patients also had nor- al thyroid uptake of iodine. One report mentions a ight thyroid enlargement.[9]

The patient described here had an increased iodine ptake along with a mild thyroid enlargement; no ason for this elevation is apparent. She took no anti- yroid drug, had no antimicrosomal or anti- yroglobulin antibodies, and did not come from an dine deficient area. She does not have coincidental inical hyperthyroidism. Whether this abnormality of yroid uptake in conjunction with FDH has any inical importance remains to be determined.

Along with an elevated T_4 level, the increased uptake lds another confusing laboratory abnormality noted occur in patients with FDH. This further may incor- ctly suggest hyperthyroidism. A normal T_3 RIA and RH stimulation test will help identify this problem. The familial nature of this disorder strongly is sug- sted as the brother of the patient showed laboratory ta compatable with the FDH syndrome: an elevated , a high-normal T_3 RU, but a normal T_3 RIA and a rmal free T_4. Formal electrophoretic confirmation nfortunately was unavailable.

MMARY

A patient with familial dysalbuminemic hyper- roxinemia is presented. In contrast to the few viously reported cases, this patient had an elevated ine uptake along with an enlarged thyroid gland. In addition to an increased T_4 level, confusion with a hyperthyroid state was suggested. A normal T_3 RIA and TRH stimulation test helped differentiate this problem.

REFERENCES

1. Ruiz M, Rajatanavin T, Young RA, et al.: Familial dysalbuminemic hyperthyroxinemia: A syndrome that can be confused with thyrotoxicosis. *N Engl J Med* 306:635-639, 1982.

2. Lee WNP, Golden MP, Van Herle AJ, Lippe BM, Kaplan SA: Inherited abnormal thyroid hormone-binding protein causing selective increase of total serum thyroxine. *J Clin Endocrinol Metab* 49:292-299, 1979.

3. Hennemann G, Docter R, Krenning EP, Box G, Otten M, Visser TJ: Raised total thyroxine and free thyroxine index but normal free thyroxine. *Lancet* 1:639-642, 1979.

4. Stockigt JR, Topliss DJ, Barlow JW, White EL, Hurley DM, Taft P: Familial euthyroid thyroxine excess: An appropriate response to abnormal thyroxine binding associated with albumin. *J Clin Endocrinol Metab* 53:353-359, 1981.

5. Borst GC, Premachandra BN, Osburne RC, Burman KD, Johnsonbaugh RE: Euthyroid, familial hyperthyroxinemia due to an abnormal thyroid-hormone-binding protein. 63rd Annual Meeting, Endocrine Society, Cincinnati, OH, June 17-19, 1981.

6. Moses AC, Lawlor J, Haddow J, Jackson IMD: Familial euthyroid hyperthyroxinemia resulting from increased thyroxine binding to thyroxine-binding prealbumin. *N Engl J Med* 306:966-969, 1982.

7. Refetoff S: Thyroid function tests, in: DeGroot LJ (ed), *Endocrinology*. New York, NY, Grune & Stratton, 1979.

8. Refetoff S, DeWind LT, DeGroot LJ: Familial syndrome combining deaf-mutism, stippled epiphysis, goiter, and abnormally high PBI: Possible target organ refractories to thyroid hormone. *J Clin Endocrinol Metab* 21:279-294, 1967.

9. Weintraub BD, Gershengorn MC, Kourides IA, et al.: Inappropriate secretion of thyroid-stimulating hormone. *Ann Intern Med* 95:339-351, 1981.

COMMENTARY: DRG—NEW JERSEY AND THE FEDERAL SYSTEM*

BERNARD A. RINEBERG, M.D., NEW BRUNSWICK**

Major differences between New Jersey and federal DRG exist, yet no conclusion can be surmised because of incomplete data. Nonetheless, the federal government has adopted and modified the plan. These modifications could have a major impact on the New Jersey system.

On October 1, 1983, two significant events occurred simultaneously. Most prominently, the American Telephone and Telegraph Company underwent divestiture. Secondly, and possibly just as importantly, prospective reimbursement to hospitals based upon case mix or more commonly known as Diagnosis Related Groups (DRGs) became the method of payment for Medicare recipients to hospitals in this country. These events are not entirely unrelated.

In the case of AT&T, a giant 19th-century monolith was broken up to create competition between the different factions. In the case of DRGs, hospitals will become more competitive to maintain their existing market share. In both industries, the ability to control costs and increase productivity while simultaneously decreasing excessive spending will be crucial to success. However, in either case, there is no assurance that the programs can or will achieve the goals which their proponents have predicted.

The DRG experience became operational in 1979 for more than 20 hospitals throughout New Jersey. Soon after, all hospitals were phased in. Actually, DRG had its genesis in the Yale School of Public Health. The original system identified categories of diagnosis which could be interrelated on the basis of consumption of hospital resources. One of the students at that time was later to become New Jersey State Commissioner of Health and, virtually, the czar of health and hospital reimbursement in New Jersey.

In 1976, the United States Health Care Financi Agency awarded the New Jersey Department of Hea a three million dollar grant to explore alternatives the per diem system of hospital reimbursement.

It should be no surprise to anyone that DRGs ha become the law of the land. The actual intent of t original grant was to devise a new method of rei bursement for inhospital treatment. In the first f years of DRG, many hospitals did very well financia and very few did poorly. In fact, early on, several hos tals made inordinate amounts of money. Sources w served in the New Jersey State Department of Hea let it be known that this device was used to make t system seem palatable and also to make it politica acceptable.

We must beware of comparisons of the New Jer system with the federal plan because there are marl and rather critical differences between them. Soon y will see why we in New Jersey should be grateful t we have a waiver from the federal system.

There are three statements concerning DRGs in N Jersey which can be agreed upon: (1) The DRG syst is implementable. In other words, the prospective rei

*This paper was read in part at the Annual Meeting of American Orthopaedic Association, The Homestead, Springs, Virginia, June 27, 1983.

**Correspondence may be addressed to Dr. Rineberg at George Street, New Brunswick, NJ 08901.

ursement system based on diagnostic groups by case ıix can be used as a basis for hospital reimbursement. 2) Start-up costs are high. Additional medical record ersonnel must be hired. They must code the medical hart in such a way as to maximize potential reim-ursement. Hospitals must hire DRG coordinators, eretofore unknown professionals, who demand alaries of up to $35,000. This is just the start. This oes not include additional costs for developing soph-ticated software for comparing clinical activity with nancial performance—essential and very expensive. ı addition, fees may have to be paid to special legal ounsel when engaged to develop appeal documents milar to those used in public utility cases. The Big 3" accounting firms have created divisions dedicated helping hospitals take full advantage of this new imbursement system. (3) The system's efficiencies e yet to be confirmed. No one knows whether the stem has saved money, can save money, is wasteful, harmful, is helpful, or is a combination of all three. Interestingly, the important studies of the early years DRG are seriously in arrears. Conclusions as to hether or not New Jersey exceeded the cap allowed ıder the federal waivers awaits the rate appeal pro-ss for the years 1979 to 1982 which are not com-eted.

Six major items differentiate the New Jersey system om the federal system: (1) The system is limited to edicare inpatients and does not include other payors.) Nonmedical indigency costs are not included. (3) rect medical education costs are a "pass through" th the indirect costs given only special consider-ion. (4) Although capital and construction costs are ssed through as a separate item, there is a potential sk of retroactive denial of these expenses beginning arch 1983. (5) Outliers are limited to not less than percent or more than 6 percent of the total allowed RG reimbursement. (6) Eventually, all acute care hos-tals in the country will be based upon the same ndard rate and adjusted only on the basis of geo-aphic area, that is indigenous labor costs.

n New Jersey, all carriers are charged the same ıount for the same diagnosis, whether they be Medi-re, Medicaid, or any other payor. Federal DRG is ıited just to Medicare inpatients. Previously in New rsey, we had a system in which different carriers re paid differential rates. Some were regulated while ıers were not. Cost shifting was the rule. Although e federal system has been critical of cost shifting in e past, their introduction of prospective reimburse-nt only for Medicare will serve to further promote s activity. It will allow HCFA to look like it is saving llars while in the terms of the real world, this may t be factual. In fact, bills to other carriers and indi-luals could skyrocket.

ndigency costs are factored into the New Jersey re-bursement formula. In other words, the DRG reim-rsement for each hospital has taken into consider-on a portion of the cost associated with patients able to pay hospital bills. This additional markup tor is not dissimilar to what occurs in other busi-sses. As an example, when you purchase shaving am the cost includes the shopkeeper's loss due to ential damage, pillage, or theft. No provision, how-r, has been made under the federal DRG to make up for this type of loss. This should have significant impact upon both the urban hospitals and the teaching hospitals who have experienced an increasing indigency load. This matter has not yet been fully resolved and hopefully when the regulations are promulgated at the end of the summer, a more enlightened posture will be brought forth.

Direct medical education costs have been a "pass through" irrespective of classification, i.e. major or minor teaching hospitals. Although this "pass through" remains intact in both the New Jersey and federal systems, the New Jersey Hospital Ratesetting Commission has expressed grave concern as to its continued support of this "philosophy." In fact, they have recommended the creation of yet another commission to review the cost of medical education and who should be responsible for payment. Reimbursement for medical education by Washington-based regulators may become a reality and include limitation of reimbursement in different specialties, for different educational needs, and for different types of medical education programs. This is occurring at a time when the total financial pot is fixed and shrinking and with state and federal legislators continuing to seek further ways to reduce health care costs. The current "pass through" for residents' salaries is generous, but this largess must be considered soft money.

Capital and construction costs under the New Jersey experience are considered a "pass through." The federal legislation mandates that HHS perform a study to determine method of reimbursement for capital related cost (which includes construction). The study may go on for 18 months. There is no assurance that capital projects including purchase of new technology after March 1, 1983, will be funded. With a single stroke, the secretary of HHS could throw our hospitals of the future into a chaotic state.

Outliers are the part of the problem which may affect both hospitals and physicians the most in the future. Under the DRG scheme, there are 467 different groups. Outliers are patients who display inordinate consumption of hospital resources either in terms of clinical services or length of stay when compared with patients who possess similar medical attributes. Outliers are figured separately and adjusted by a separate formula. This gives hospitals a method of fair reimbursement for a patient who consumes resources at an inordinate rate. This may include but is not limited to the complicated total hip revision, severe poly-trauma, or cerebral palsy victim who requires a myriad of possible procedures. Outliers are identified not only by complicated and nonconforming diagnosis but also by a hospital stay which severely deviates from the norm.

Approximately 35 percent of New Jersey's patients are outliers for whom hospitals are paid on a separate basis. New Jersey outliers generate approximately 40 to 50 percent of the funds allocated to the hospitals. Dropping this 35 percent outliers to the 5 or 6 percent mandated under the federal law will create some rather stringent problems on the provision of patient care. Virtually all patients will be assigned to a diagnostic group regardless of how they compare to the normal within that DRG. The patient who will be high cost to the hospital and should but could not be placed in an outlier category will be most unwelcome by the hospi-

tal administrator. For instance, the poly-trauma no longer may be admitted to the community hospital. That patient will be transferred to minimize financial loss. The end result will be regionalization. Perhaps that will be good, however, it will present the possibility that other parts of the system as we now know them will have to be changed.

The young orthopedist with a strong inclination for traumatic spine surgery will no longer have the ability to set up practice where he wants, but will be forced to stay near the large center. He will become the direct competitor of his teachers, which could increase the friction between the student now turned competitor and the teacher. How this will affect medical education and medical practice in the future cannot be determined at the present time but it certainly bears watching.

The patient who will be high cost to the hospital and should but could not be placed in an outlier category, will be most unwelcome by the hospital administrator.

Another major problem is uniform reimbursement to all hospitals. Very soon all hospitals in the United States will receive the same amount of money for each diagnosis with slight regard for labor differential. This will be irrespective of the hospital's mission, geography, or special care consideration. There will be no adjustment for severity or complexity of the disease. This formula could have dire effects on dedicated tertiary care facilities. It carries with it the potential of threatening hospitals specializing in very complicated and expensive problems.

As originally stated, there are no factual answers to the question, "Has DRG worked in New Jersey?" There is no evidence at the present time under any system that there are any differences in the way individuals practice before or after DRGs. Rumors that hospital administrators have stalked the halls trying to oust patients are not true. The anecdotal evidence of patients being forced out by the hospitals has yet to be substantiated. Likewise, claims of cost savings are yet to be proved. Reduction in the average length of stay again is yet to be proved. Efficiencies in the institutions and how they manage their affairs is yet to be proved.

But the system may have merit. It gives those sponsible the ability to ratchet down the system. It c be used to coerce early discharge and make one thi twice before ordering expensive or duplication of la oratory or x-ray examination. It certainly will ma obsolete the phrase, "Let's do it for completeness sak It can slow and hamper innovation. DRG coordinat review major equipment requests to determi profitability to the hospital. Administrators as well colleagues carefully will examine new requests utilization of resources especially those in which th is potential for loss.

Standard delivery of care will have to be accep most readily. Deviations will be questioned. Simp straightforward, and uncomplicated cases will be favor while the complicated and the complications well will become close to unacceptable.

To some it may seem mind boggling that the N Jersey model which is unproved has been rapidly d seminated. This, however, is acceptable in busin and will become more acceptable in government. Ma modifications, however, have been made to a mo which remains questionable and this may have c consequences in terms of health care delivery a medical education. They bear careful monitoring.

The federal and the New Jersey versions of DRG h serious problems. It is new, it is scary, and it is thre ening. Nonetheless it is the only alternative plan change the current per diem method which has pro itself to be wasteful. There soon may be a cap on me cal expenses in the United States especially when are spending 300 billion dollars per annum. This a ages to $6,000 for a family of four.

Certainly a part of the financial pot will go to hos tals while the rest will go to physicians. Savings in sphere could lead to less frugality in the other pecially if physicians act in a responsible manner. are living in what Peter Drucker has termed "turbul times." Major progress will be designed in econom business, and government and implemented with experimentation.

Medical leadership in New Jersey has decided mount a campaign against the DRG system. This prove unfortunate. They have not yet come up wit substantial substitute. Reintroduction of the old workable system may lead to a great deal of thrash and will be nonproductive.

True cooperation in this system is necessary tween both physician and patient and physician hospital and though the system is rough at the pres time, modifying it may lead to a system which c save money and continue to allow the highest qua medical care.

Commentary: DRG— the Executive Director's View

Vincent A. Maressa, J.D., Lawrenceville*

The DRG program and its enabling legislation are so flawed that there is no chance for success. Yet, at least by following the present policy on DRG, MSNJ will not have collaborated in the destructive course that will result when the system collapses.

Overall, it would appear that Dr. Rineberg's article (page 406) is fairly consistent with the Medical Society of New Jersey's policy in recognizing that the DRG program is not working. He departs from the Society policy by urging cooperation and modification of the DRG program so that it might save money and assure the availability of quality care.

From my perspective, the DRG program and its enabling legislation are so flawed that no modification outside of totally dismantling the entire system and format can or will produce a reasonable chance for success. The DRG concept assumes that clinical averages will occur, will be predictable, and will be a valid mechanism upon which to predicate payments for hospital services. None of that has been proved so we should examine what we do know.

"Averaging" sounds pleasant enough but generally has no basis in fact. The average American family has 1.79 children. That is absurd as a fact unless the average American woman always is pregnant. The average premium for physicians insured through the Medical Inter-Insurance Exchange of New Jersey for professional liability is $6,850. There is no class of practice that pays that rate. So much for averaging!

The DRG program has established its invalidity by the fact that even though liberal trim points are used, 35 percent of the cases are falling outside the system.

The enabling legislation is another matter. It allows hospitals to place a number of items not directly related to patient services into their base rate. It also allegedly compensates for indigent care and requires payors to pay at the same rate. At the same time, it allows discounting to Blue Cross. The state legislature could not force the federal government to do anything. The Health Care Financing Administration, therefore, gave us the DRG program but capped its liability. The system does not really compensate for indigent care. By virtue of statutory cost shifting, it simply allows hospitals to charge others more to make up their deficits. Such a concept is self-defeating because it produces higher rates for the same DRG in the hospitals with significant indigent patient populations as opposed to other hospitals. The paying population now has begun to realize this and the business community actively is steering patients away from these hospitals. As more and more paying patients go elsewhere, the financial base of the high indigent hospital deteriorates. The Health Department's answer is to continue the cost shift by letting the hospital charge more for its services.

Blue Cross is allowed a 10 to 15 percent discount under the program. Self-insureds such as union and welfare funds, can pay charges or DRGs, whichever are lower since they are not "insurance companies." Insurance companies are paying DRGs most of the time,

*Mr. Maressa is the Executive Director, MSNJ.

but really do not have to, according to the Department of Insurance. All they must do is honor their policies which almost always cover "incurred or actual charges." Once these carriers realize what their options are, they will pay DRG or incurred charges, whichever are lower. The federal government is into this situation on its own terms. If DRGs in other states produce a lower rate, I am sure the "waiver" will be extinguished. The new "waiver" also requires that HMOs be allowed to discount even though they do not fit the discount criteria established in our state statutes. The best one can say about the effect of the statute is that it cannot be implemented.

All our readers know that comparing our rate of cost increase to national averages is silly since we have always been below them. For the past six years prior to DRG, we averaged 3.5 percent below the national average. The first year of DRG, we came in 3.4 percent below the national average. The next year we came in 4.7 percent below the national average. That looks encouraging until you realize that the national average of cost increase in that particular year was 1.7 percent greater than the established trend had been.

The most telling statistic which the Department o Health does not want to discuss, however, is the in creased price to the patient. According to the Depart ment of Health, in the first year of DRG net patien service revenue increased 22.6 percent. Since the cost increased 13.6 percent, it is fair to assume the cost t the public went up about 36 percent if not more. Th next year, the net revenues increased by 14.8 percen and costs went up 14.0 percent for a change in pric to the patient of at least 28.8 percent if not more.

I do not see any way for MSNJ to effect any reasor able changes in the system. The state and federal gov ernments hardly can be expected to admit error. Whe the system collapses they likely will point to the med cal profession. At least by following the present cours we will not have collaborated in the destructive cours that resulted. Most of the factors producing these cos escalations are well beyond the control and manage ment of the practicing physicians. Physicians are n more responsible for what has occurred than they ar for the cost of auto insurance in this state.

IMAGING: AN APPROACH TO THE DIAGNOSIS OF CHOLECYSTITIS*

LOUIS S. ZEIGER, M.D., CAMDEN**

What imaging procedure should you consider when suspecting gallbladder disease? This article discusses the use of ultrasonography and hepatobiliary scan.

What imaging procedure should you consider when suspecting gallbladder disease? This article ill discuss the use of ultrasonography and hepatobil- ry scan.

LTRASONOGRAPHY

Ultrasonography of the gallbladder using high fre- uency sound waves in the MHz (megahertz) range sualizes the gallbladder as a fluid-filled, echo-free gan (Figure 1). The image represents the distribu- on of tissue acoustic impedance. The presence of hoes in the gallbladder which are mobile and cause minished sound transmission are diagnostic of olelithiasis. The accuracy of gallstone detection is 95 rcent using ultrasound examination (Figure 2). Gall- ones as small as 2 to 3 mm have been detected. andard x-ray oral cholecystogram has a 90 percent erall accuracy in patients with a visualized llbladder. However, there are many reasons why the llbladder may not be visualized: nausea, vomiting, or arrhea. The ultrasound procedure is the most ac- rate, noninvasive technique to establish the agnosis of cholelithiasis, which invariably is as- ciated with chronic cholecystitis. In addition, in the tient with suspected biliary obstruction, the ultra- und examination is a sensitive indicator of intra- or trahepatic bile duct size and, therefore, the site of struction. In the presence of chronic cholecystitis, the diagnosis of acute cholecystitis is not reliably made by ultrasound. Pathologically, the majority (98 percent) of surgically verified acute cholecystitis is associated with cystic duct obstruction. The presence of a thickened wall greater than 5 mm and a cystic duct stone are rarely seen by ultrasonography study.[1]

HEPATOBILIARY SCAN

The study of choice in the diagnosis of acute cholecystitis is hepatobiliary scanning (HBS) with Tc99-disofenin or cholescintigraphy. If serum bilirubin is less than 8 mg/dl, the procedure is valid.

The radionuclide tracer, Tc99-disofenin, when injected intravenously, is selectively excreted by the hepatocytes into the biliary system. Approximately 90 percent of the tracer is excreted into bile if the serum bilirubin is normal. By 20 to 30 minutes after the injection, the gallbladder and common duct are seen clearly (Figure 3A) and cystic duct obstruction has been excluded. If the gallbladder is not visualized by 3 hours after injection and the common duct seen,

*IMAGING is a new column to be presented in *The Journal* under the direction of Judith K. Amorosa, M.D., Director of Medical Education, Department of Radiology, UMDNJ-Rutgers Medical School.

**Dr. Zeiger is Chief, Division of Nuclear Medicine, Cooper Hospital/University Medical Center, Camden. Correspondence may be addressed to Dr. Zeiger, Cooper Hospital/University Medical Center, One Cooper Plaza, Camden, NJ 08103.

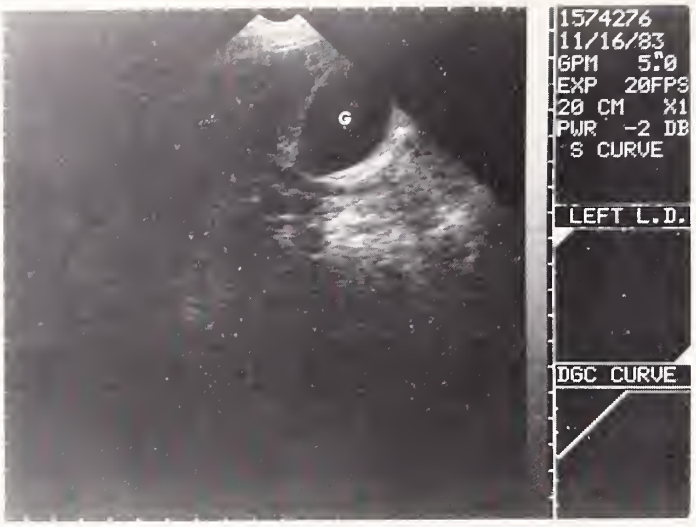


Figure 1—Ultrasound of the gallbladder. Left lateral decubitus projection demonstrates an echo-free gallbladder (G).

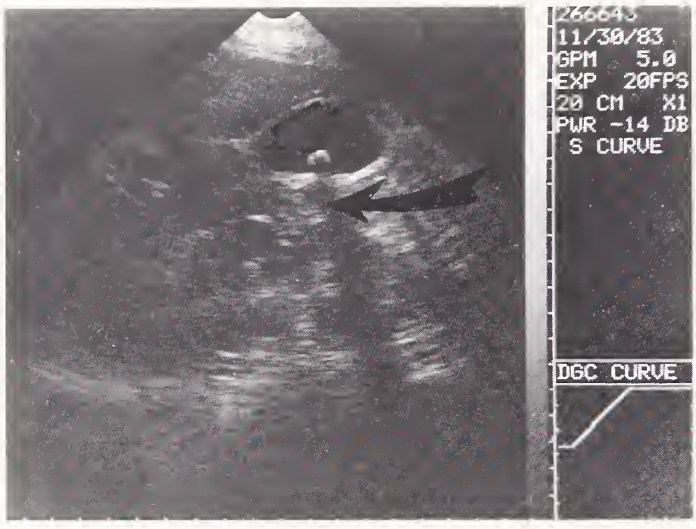


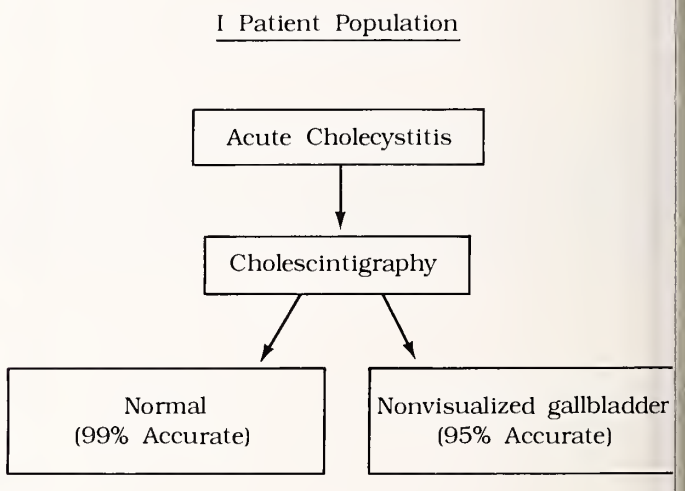
Figure 2—Ultrasound of the gallbladder. Longitudinal projection demonstrates echoes secondary to gallstones (open arrow head). Curved arrow points to so-called acoustic shadowing, area beyond stones where sound is not transmitted.



Figure 3A—Hepatobiliary scan Tc99-disofenin normal study. Anterior view 30 minutes after injection visualizes the gallbladder (GB), as well as, medial to it, the common duct and small bowel activity.



Figure 3B—Hepatobiliary scan Tc99-disofenin. Anterior vie at 45 minutes after injection fails to visualize the gallbladde but the common bile duct (CBD) and small bowel (SB) a seen. The study is diagnostic of acute cholecystitis.



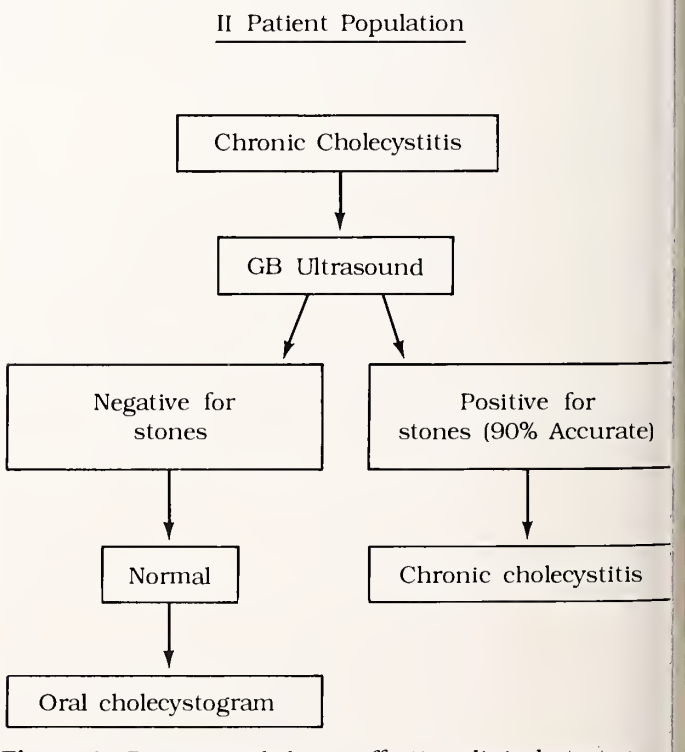


Figure 4—Recommended cost-effective clinical strategy.

cystic duct obstruction is implied (Figure 3B).

Weissman et al.[2] studied 352 patients prospectively for acute cholecystitis with the following results: 1 Gallbladder visualization accurately excluded th

diagnosis in 99.2 percent; the false negative rate was .8 percent. 2) Gallbladder nonvisualization (up to 3 hours) confirmed acute cholecystitis in 95 percent of patients surgically confirmed. That is a 5 percent false positive rate primarily secondary to severe chronic cholecystitis.

CONCLUSION

The presence of a normal hepatobiliary scan or visualization of the gallbladder by one hour excludes the diagnosis of acute cholecystitis in most patients. Acalculous cholecystitis occurs in 1 to 5 percent of all patients. A normal hepatobiliary scan might be expected but the observed false negative rate is 1 percent suggesting a lower incidence (Figure 4).

REFERENCES

1. Shuman WP, et al.: Ultrasonic diagnosis of acute and/or chronic cholecystitis. *AJR* 139:61-64, 1982.
2. Weissman HS, et al.: Spectrum of 99m Tc-IDA cholescintigraphic patterns in acute cholecystitis. *Radiology* 138:167-175, 1981.

Close your eyes.

Now have someone read this to you.

You are blind. A student. Facing four years of college. With about thirty-two textbooks to read. Plus fifty supplemental texts. How are you going to manage?

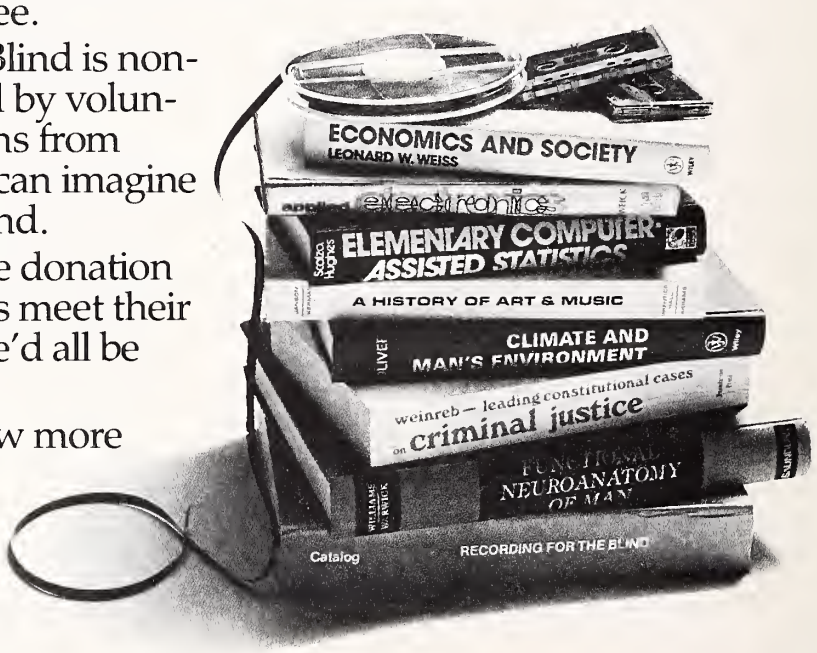
With Recording for the Blind. Since 1951, we've helped over 60,000 blind, perceptually and physically handicapped students get through school. By sending them recordings of the books they need to read. Free.

Recording for the Blind is non-profit, and supported by volunteers and contributions from people like you who can imagine what it's like to be blind.

Your tax-deductible donation will help our students meet their educational goals. We'd all be grateful.

If you want to know more about us, write:

Station G
Recording for the Blind, Inc.
20 Roszel Road
Princeton,
New Jersey 08540



Recording for the Blind, Inc.

AN EDUCATIONAL LIFELINE.

Current Nutrition: Diet And Nutrition in Chronic Renal Failure*

Norman Lasker, M.D., Newark**

Signs and symptoms of uremia are related to products of protein metabolism. Hence, protein restriction is the cornerstone of nutritional management in patients with chronic renal failure. Protein restriction must be associated with a high caloric intake to be effective.

There are three basic modalities for the treatment of patients with established chronic renal failure: diet, dialysis, and transplantation. Of the three, diet is the most pervasive since it is applied independently or in conjunction with the others, i.e. to a large extent the success of chronic dialysis depends on the patient's adherence to a strict dietary regimen. The chronic dialysis patient does not enjoy optimal good health and the transplantation patient is subject to the uncertainties of kidney procurement, rejection, and the serious side effects of immunosuppressant drugs. The suggestion that an appropriate diet can slow the progression of chronic renal failure to the stage where dialysis and transplantation are required, enhances the importance of careful dietary and nutritional management.

The objectives of the nutritional management of patients with chronic renal failure include: prevention and control of uremic signs and symptoms; decrease the progression of renal damage; and obtain the preceding without the development of protein, caloric, vitamin, and mineral deficiencies.

PROTEIN AND CALORIES

Uremic signs and symptoms are related, in large part, to products of protein metabolism, including polypeptide middle molecules, urea, guanidinosuccinic acid, methyl guanidines, methylamines, and phenolic acids. Proteins also are the source of hydrogen ions, potassium, and phosphorous, which tend to accumulate and produce toxic effects in renal failure. Therefore, the basis of diet therapy is protein restriction.

Thomas Addis's[1] suggestion that protein restriction slows the progression of renal failure has been championed by Barry M. Brenner and his associates[2] who hypothesize that a protein-induced increase in single nephron glomerular filtration and permeability facilitates the filtration of plasma proteins. The accumulation of plasma proteins in the glomerular mesangial cells stimulates them to produce glomerular sclerosis. Since dietary restriction of phosphate decreases the progression of experimental renal failure through decreasing hyperparathyroidism and/or preventing interstitial deposition of calcium phosphate crystals, some of the beneficial effects of protein restriction may be due to associated phosphate restriction.[3]

Renal histology in chronic renal failure is nonspecific and one cannot predict the rate of pro-

*This column is prepared under the direction of Herman Baker, Ph.D., Professor, Preventive Medicine/Community Health and Medicine, UMDNJ-New Jersey Medical School.

**From the division of nephrology, UMDNJ-University Hospital, Newark. Correspondence may be addressed to Dr. Lasker, Medical Science Building, Room I-514, UMDNJ-University Hospital, 100 Bergen Street, Newark, NJ 07103.

gression of renal disease by its etiology. However, the rate of progression is consistent in any individual patient. A graph plotting the reciprocal of the serum creatinine against time gives a descending straight line curve and can be used to monitor the effects of dietary manipulations on the progression of the renal disease.[4] Using this method, Maschio et al. have shown a low protein-phosphorous diet decreases the progression of chronic renal disease in azotemic patients with serum creatinines ranging from 1.60 to 5.40 mgm percent.[5]

It is critical to provide the benefits of protein restriction without producing protein-calorie malnutrition and depletion of vitamins and minerals. Approximately 70 percent of the protein should be of high biological value defined as proteins containing a high percentage of the essential amino acids in the proportions required by humans to allow their efficient incorporation into body proteins. High biological protein foods are eggs, milk products, meat, poultry, and fish. Patients with renal failure frequently are anorexic because of the accumulation of uremic toxins, medications, and emotional depression. The anorexia is accentuated by dehydration and acidosis. A vicious cycle may develop whereby anorexia and emesis resulting from uremic toxicity dehydrate the patient and further decrease renal function. Temporary measures such as intravenous fluids or acute peritoneal dialysis may be required to break the cycle and allow the acceptance of the therapeutic diet.

A high caloric intake of at least 35 Kcal/kgm body weight is essential to the success of a low protein diet. Inadequate caloric intake promotes protein breakdown by gluconeogenesis and causes negative nitrogen balance. The protein restricted diet must be compatible with the patient's tastes to encourage his compliance and insure adequate caloric intake. High calorie, low protein supplements such as Hycal®, Polycose®, or Controlyte® may be required to meet the caloric requirement. The protein and caloric intake may have to be increased during periods of stress such as gastrointestinal bleeding, surgery, trauma, or infection. This may necessitate hyperalimentation by gastric feeding tube or central vein. Protein losses in the urine can be replaced by increasing the protein intake by 1.4 gm for each gram of protein in the urine based on 70 percent protein utilization.[6]

Although protein-restricted diets previously were started when patients developed signs and symptoms of uremia, the possible role of protein in accelerating the progression of renal failure indicates an earlier use of these diets. This diet also should be considered in any azotemic patient with chronic renal failure and an increasing serum creatinine. The level of protein intake is based on residual renal function as well as the clinical picture; thus, it may be necessary to decrease the protein intake if the patient is symptomatic at intake levels indicated by the creatinine clearance (Table 1).

As creatinine clearance decreases below 6 ml/min, it may become difficult to maintain the patient free of uremic signs and symptoms on a 40 gm, high-biological value diet. Restricting the protein intake below this level results in a less-appetizing diet with poor patient compliance and the development of protein and caloric malnutrition.[7] Bergstrom and his associates have utilized an unselected protein-poor diet of 16 to 20 gm supplemented with 10 to 20 gm of essential L-amino acids plus histidine as the acetate salt (Aminess®).[8]

TABLE 1

Protein Restriction in Relation to Residual Renal Function

Protein Intake	Creatinine Clearance
Gms/kgm/day	mls/min
0.8*	15 to 30
0.6*	6 to 15
0.3 + 0.2 of essential L-amino acids + histidine	< 6

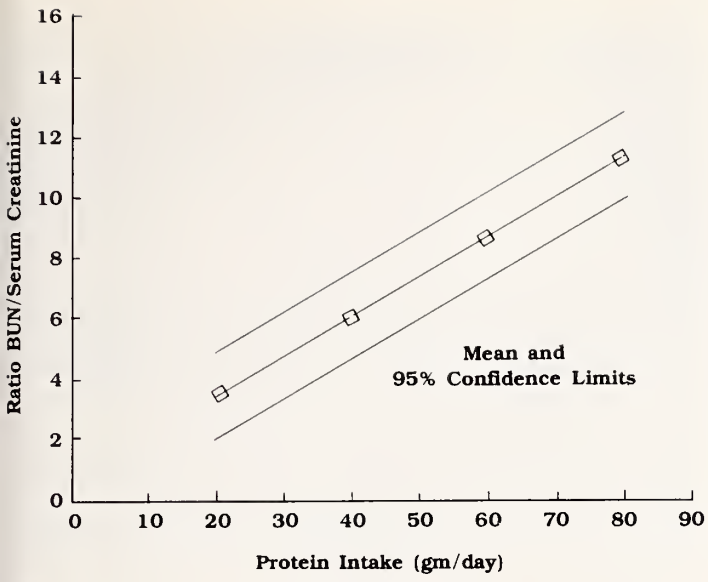
* = > 70 percent of high biological value protein.

By allowing low-quality protein, the diet is more varied and better patient compliance is achieved. Clinical results are impressive with the abatement of uremic symptoms and improvement in the patient's strength and vigor.*

Despite the protective effects of low protein diets, these patients eventually will need dialysis or transplantation. This is indicated when the patients develop congestive heart failure despite salt restriction and large doses of "Loop" diuretics, pericarditis, bleeding, neuropathy and persistent nausea, vomiting, and malaise. (Correctible factors such as obstruction, prerenal failure, and drug-induced decreases in renal function should be considered first.)

Protein-restricted diets tend to be boring but patient compliance can be enhanced by a team approach involving the patient and family with physicians, dietitians, nurses, and social workers. The physician should instruct the patient and his family on the rationale of the diet and stress its importance by checking the patient's compliance at each visit. The dietitian should adjust the diet within the restricted guidelines, but attempt to select foods which are to the patient's liking. The dietitian excels in obtaining the dietary history, establishing a patient's caloric and protein requirements on the basis of deviation from ideal body weight and nutritional status, and translating that data into a meal plan. Nutritional status may be assessed from measurements of height and weight, skin fold thickness, midarm muscle circumference, and growth in children. Useful laboratory guides include the level of total serum proteins, serum albumin, serum transferrin, and C3 (complement).[10] Other laboratory parameters such as decreased ratios of essential to nonessential amino acids are not generally available. The adherence of the relatively stable patient to the protein and caloric requirements of the diet also can be monitored by examining the BUN/creatinine ratio. Since the serum urea level mainly is based on protein intake, protein metabolism, and renal function while the serum creatinine level mainly is determined by renal function, the relation between the two is a useful index of protein intake. Other factors influencing the ratio such as increased protein

*The use of keto analogues of the essential amino acids to decrease nitrogen accumulation still is experimental; the analogues are not available commercially.[9]



Figure—Direct relationship between blood urea nitrogen (BUN)/serum creatinine ratio and protein intake in stable chronically uremic men.[11]

catabolism, dehydration, extremely small muscle mass, and advanced hepatic disease usually are obvious.[11] A stable, chronically uremic patient on a 40 gm protein intake should have a BUN/creatinine ratio of approximately 6 while a ratio greater than 7.5 suggests a higher protein intake (Figure).

VITAMINS

Most of the data indicating clinically significant vitamin deficiencies in chronic renal failure were obtained in patients on chronic dialysis.[12] These deficiencies involve water soluble, nonprotein-bound vitamins which are removed by the dialytic treatment. However, potassium-restricted diets may be low in water soluble vitamins and supplements may have prophylactic value (Table 2). Fat soluble vitamins are not recommended routinely because their blood levels usually are normal or elevated and they are potentially toxic. Blood levels of 1-25 dihydroxycholecalciferol, the active metabolite of vitamin D, are low in the late stages of renal failure, but supplements usually are not given until the patient is on dialysis because of the dangers of calcium-phosphatase precipitation in blood vessels and organs (vide infra).

SODIUM AND WATER

The George Schreiner concept of "homeostenosis" in patients with chronic renal failure indicating a relatively fixed renal salt and water excretion which is only minimally responsive to acute changes in intake is very appropriate.[13] A good guide to the sodium requirement is the measurement of 24-hour urinary sodium excretion after three days of a constant 2 to 3 gm sodium intake. Salt intake should be set at the maximum level which does not lead to heart failure or pulmonary edema. Rapid fluctuations in body weight usually are due to changes in salt and water intake and not caloric balance. Sympatholytic agents and vasodilators may be better therapy than severe salt restriction for hypertension in some patients with chronic renal failure because of the danger of hypovolemia and decreased renal function when the sodium excretion is excessive.

TABLE 2

Vitamin Supplements in Chronic Renal Failure

Vitamin	Dose mgm/day
Thiamin	1.5
Riboflavin	1.8
Pantothenic acid	5
Niacin	20
Pyridoxine	5
Ascorbic acid	100
Folic acid	1
B_{12}	(none necessary)

Berocca® is a water soluble vitamin which provides these vitamins.

When the thirst mechanism is intact, water intake usually is dependent on salt intake. A pathological increase or decrease in water intake is indicated by hypo- or hypernatremia. Patients usually will remain eunatremic if allowed free access to water providing there are no superimposed problems such as cardiac failure, administration of potent "Loop" diuretics, or inappropriate intravenous fluids.

POTASSIUM

Potassium restriction below the 2 to 3 gm provided by a low protein diet usually is not necessary. Potassium excretion is maintained at this level despite a marked fall in renal potassium filtration by adaptive increases in Na+ - K+ ATPase activity of renal tubular and gastrointestinal cells. Hyperkalemia may occur in the presence of oliguria, marked dietary indiscretions, K+ retaining diuretics, or increased catabolism and tissue breakdown. The prostaglandin-inhibiting anti-inflammatory agents may decrease renal blood flow, lower renin-aldosterone production, and potassium excretion.

Hyperchloremic acidosis associated with hyperkalemia (type IV renal tubular acidosis) may be seen in mildly azotemic patients with diabetes mellitus and decreased autonomic innervation of the juxtaglomerular apparatus producing hyporeninism and hypoaldosteronism. A similar picture is seen in some patients with chronic interstitial renal disease as the tubules no longer are responsive to aldosterone. The acidosis and hyperkalemia may respond to the potassium lowering effect of "Loop" diuretics, sodium bicarbonate administration, potassium exchange resins, and poorly absorbed polysaccharides such as Sorbitol®. An aldosterone substitute such as Florinef® may be indicated in the patients with low renin and aldosterone who are not in heart failure or markedly hypertensive.

ACIDOSIS

Metabolic acidosis in chronic renal failure usually is caused by decreased ammonia production due to lack of functioning tubular cells. The associated high anion gap is due to the retention of inorganic "acid" anions such as phosphate and sulfate. The hydrogen ions associated with these fixed acids are acutely buffered by bicarbonate, but on a chronic basis much of the

buffering occurs in the bone with the liberation of calcium carbonate and the development of osteopenia. To prevent this sequence, it is recommended that the serum bicarbonate be maintained at the level of 20 MEq/liter with sodium bicarbonate supplements. Sodium bicarbonate more readily is excreted than sodium chloride in these patients and is less likely to produce congestive heart failure.

CALCIUM AND PHOSPHOROUS

As the glomerular filtration rate decreases, phosphorous is retained. The elevation in serum phosphorous lowers the serum calcium level (the product of $[Ca^{++}]$ x $[PO4^{=}]$ usually is maintained in 30 to 40 range) which in turn stimulates the parathyroid glands to hypertrophy. The low serum calcium concentration also may be a reflection of decreased calcium intake on a low protein diet and a decrease in the renal production of the active vitamin D derivative, 1-25 dihydroxycholecalciferol. The decrease in vitamin D activity inhibits calcium absorption from the intestine and its release from bone.

Therapy is directed to lowering phosphorous intake by a low protein diet with limited milk products. Despite the low phosphorous diet, aluminium hydroxide and aluminium carbonate antacids usually are necessary to reduce phosphorous absorption and achieve a normal phosphorous level. Calcium supplements, such as 2 to 6 gm of calcium carbonate (40 percent calcium), are indicated because of the low calcium content of the protein restricted diets and the decreased vitamin D activity. However, calcium supplements should not be given until the serum phosphorous is reduced to the normal range of 3.5 to 4.5 mgm/dl. Allowing the calcium-phosphorous product to rise above 50 may increase the rate of progressive renal damage as well as result in extrarenal calcification.

Active vitamin D metabolites usually are not given to patients with chronic renal failure who are not on dialysis because of the dangers of intra- and extrarenal calcium phosphate precipitation. Since increased parathyroid hormone levels may contribute to many uremic signs and symptoms such as bone disease, myopathy, anemia, pruritis, encephalopathy, and sexual dysfunction, it is important to maintain a normal serum calcium level. This best is achieved by lowering the serum phosphorous with a low phosphorous intake and aluminium antacids followed by calcium supplements, if needed.

SUMMARY

The signs and symptoms of uremia chiefly are related to products of protein metabolism. This fact and the possibility that the progressive nature of renal disease is related to protein intake makes protein restriction the cornerstone of nutritional management in patients with chronic renal failure.

Protein restriction must be associated with a high caloric intake to be effective. Water soluble vitamin supplements are indicated in chronic renal failure because of their low level in potassium restricted diets. Aluminum antacids are required to control the high serum phosphorous levels resulting from decreased renal phosphate excretion. Elevated serum phosphorous levels, decreased dietary calcium intake, and low vitamin D activity result in hypocalcemia and secondary hyperparathyroidism. This sequence should be prevented with phosphorous binding antacids and calcium supplements. The role of vitamin D in nondialysis patients is controversial.

REFERENCES

1. Addis T: *Glomerular Nephritis: Diagnosis and Treatment.* New York, NY, Macmillan, 1950.

2. Brenner BM, Meyer FW, Hostetter FH: Dietary protein intake and the progressive nature of kidney disease. *N Engl J Med* 307:652-659, 1982.

3. Ibels LS, Alfrey AC, Haut L, Huffer WE: Preservation of function in experimental renal disease by dietary restriction of phosphate. *N Engl J Med* 298:122-126, 1978.

4. Mitch WE, Walser M, Buffington SA, Lemann J: A simple method of estimating progression of chronic renal failure. *Lancet* 2:1326-1328, 1976.

5. Maschio G, Oldrizzi L, Tessitore N, D'Angelo A, Valvo E, Lupo A, Loschiavo C, Fabris A, Gammaro L, Rugiu C, Panzetta G: Effects of dietary protein and phosphorous restriction on the progression of early renal failure. *Kidney Int* 22:371-376, 1982.

6. Giordano C: Protein restriction in chronic renal failure. *Kidney Int* 22:401-408, 1982.

7. Koppel JD, Sorensen MK, Coburn JW, Gordon S, Rubini ME: Controlled comparison of 20-g and 40-g protein diets in the treatment of chronic uremia. *Am J Clin Nutr* 21:553, 1986.

8. Bergstrom J, Furst P, Noree LQ: Treatment of chronic uremic patients with protein-poor diet and oral supply of essential amino acids. I. Nitrogen balance studies. *Clin Neph* 3:187-194, 1973.

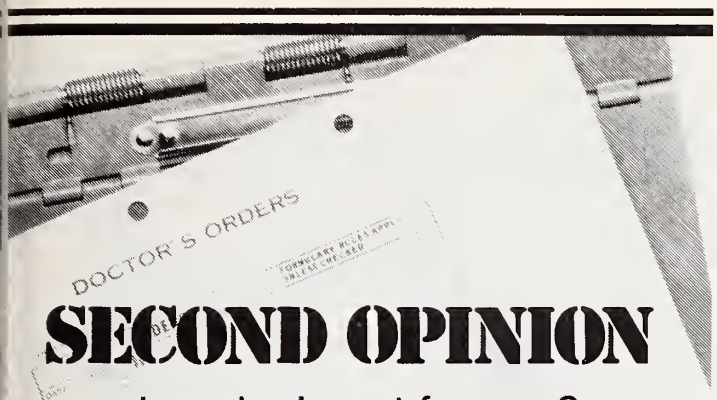
9. Walser M: Nutritional management of chronic renal failure. *Am J Kidney Dis* 1:261-275, 1982.

10. Kopple JD: Nutritonal Management, in Massry SS, Glassock RJ (eds), *Textbook of Nephrology.* Baltimore, MD, Williams and Wilkins, 1983, pp. 8.3-8.13.

11. Kopple JD, Coburn JW: Evaluation of chronic uremia. Importance of serum urea nitrogen, serum creatinine, and their ratio. *JAMA* 227:41-44, 1974.

12. Lasker N, Harvey A, Baker H: Vitamin levels in hemodialysis and intermittent peritoneal dialysis. *Trans Am Soc Artif Intern Organs* 9:51-56, 1963.

13. Schreiner G: Personal communication.



SECOND OPINION

Leasing's not for you?

Compare these figures (based on a $20,000 vehicle):

DUE 1ST DAY	PURCHASE	LEASE*
6% sales tax	$1200	$25/mo.
down payment	4000	none
monthly payment	554	410
total due:	**$5754**	**$435**

So by leasing, you've got $5319 savings on your initial outlay, plus $119 a month, to invest any way you'd like! And insurance is available to qualified N.J. motorists for as little as $600 a year. Call for similar savings on ANY make or model, foreign or domestic. *36-mo/closed-end

value lease inc

Evenings and weekends, call (201) 530-4088

1 Monmouth St., Red Bank, N.J. 07701 (201) 530-1282

SUPPOSITORY THERAPY

DESIGNED FOR YOUR SPECIALTY.

VAGINAL	RECTAL	URETHRAL
Progesterone	Hydrocortisone	Nitrofurantoin (Plain & with HC)
Boric Acid	Lidocaine	Hydrocortisone
Ampicillin/ Nystatin	Analgesic	Tetracycline
	Emollient	Lidocaine
	Progesterone (including rectal soln's)	SMZ-TMP

All preparations are available in your choice of potency and are prepared in heat stable bases suitable for shipping via United Parcel Service (UPS) with next day delivery within a 300 mile radius.

Contact us for any special requirements that exist in your practice.

BELVIDERE PHARMACY & SURGICAL

1101 South Avenue
Plainfield, New Jersey 07062 (201) 756-6695

Doctors: Write your own prescription to cure insurance pains . . .

℞ Prescription

Name MSNJ Member

MSNJ Group Blue Cross/Blue Shield Major Medical and Dental Insurance

that provides:

- **Flexible plans**
- **Comprehensive benefits**
- **Low, competitive rates**
- **Centralized Administration**

Designed and Administered by
DONALD F. SMITH & ASSOCIATES

℞ Prescription

Name _____

Address _____

Phone _____

Please send more information on the MSNJ

- ☐ Blue Cross/Blue Shield Program
- ☐ Major Medical Program
- ☐ Group Dental Program

Return to:
Donald F. Smith & Associates
One Airport Place, Route 206 North
P.O. Box 2197,
Princeton, New Jersey 08540
(609) 924-8700, (201) 622-6046



You may think these physicians are working alone.

But they really have a team behind them.

These physicians spend most of their day working independently in a one-to-one doctor/patient relationship. And chances are that as a physician, you do too.

But even though you can't see it, there's a strong team supporting and protecting the medical profession, affecting your practice while you see patients, research new drugs or perform surgery. That team consists of *your medical societies.*

The American Medical Association and your state and county medical societies believe in the value of teamwork; that only by working together can we, in the face of an increasingly complex professional environment, protect your right to make responsible decisions on how to practice medicine.

We also believe that all medical societies — county, state, and national — have certain tasks that the individual physician couldn't possibly assume — and shouldn't have to.

Tasks such as keeping government regulations from interfering with your practice by representing your interests at local and national levels. And challenging regulatory measures that threaten you and your patients' interests by mounting legal campaigns to defend your rights — up to the Supreme Court if necessary.

Why do we believe that *teamwork* means so much to *all* physicians — even those who work "alone"?

Because ... IT WORKS.

Join Your Medical Societies Today.

For more information, contact your state or county medical societies, or call the AMA collect at 312/751-6196. Or return the coupon below to your state or county medical society.

☐ Please send me information on AMA, county, and state society membership.

☐ I am a member of my county and state societies; please send me information on joining the AMA.

Name _____

Street _____

City _____ State _____ Zip _____

County _____

Opinion: Overcoming Psychic Numbing

Bernard Grossman, M.D., Trenton*

Psychic numbing includes defense mechanisms of denial, suppression, and repression. It allows us to create an illusion of control, and our society is plagued by psychic numbing. To overcome psychic numbing we must develop a new manner of thinking.

Psychic numbing is a phenomenon that includes defense mechanisms of denial, suppression, and repression. It allows us to create an illusion of control over that which we cannot control or escape. Through psychic numbing, we avoid issues too painful or too difficult to confront. Our society is plagued by psychic numbing. The media provides a daily tale of rape, murder, brutality, and cruelty. Eventually, these events are accepted as part of the fabric of society. Indeed, they become a subliminally acceptable portion of everyday life. We become immunized to the chaos around us. Only when they affect us directly are we forced to accept the full impact of these horrors.

"The Day After," the special television presentation, stirred controversy. The film was criticized for its cinematography, character development, associated media hype, implied political statement, and lack of gore. Viewers experienced the implied deaths of billions, yet some distilled it to an intellectual movie review—denying the carnage they witnessed. This allows suppression of anxiety which is natural when viewing such destruction. Lack of anxiety leads to lack of motivation and any thoughts of activism thereby are repressed. The result is an intolerable situation. An issue that should be met with political and social activism instead is met with complacency and inactivity—the results of psychic numbing.

In order to overcome psychic numbing, it is necessary, as Einstein said, to develop a "new manner of thinking." Old ways of thinking must be re-evaluated and changed if nuclear war is to be avoided.

OLD WAYS OF THINKING

1. Deterrence. The concept that "stockpiling" leads to deterrence only pertains to conventional warfare. In a conventional sense, more weapons may translate into more security. However, while it is possible to win a conventional war, there will be no winners of a nuclear confrontation. The idea that more "nukes" translate into more security is a type of nuclear addiction. Like the drug addict, our society has developed an illusion of security (more bombs) which actually diverges from reality (safety). As the addict finds that more heroin improves a sense of security, so we are under the mistaken impression that more bombs improve our security. Unfortunately, not only will the Cruise, Pershing, and MX systems fail to increase our security, but they serve to heighten tensions by eliciting a Soviet response of reciprocal buildup. This advanced weaponry reduces the time a launch error can be detected and corrected. Its installation, while providing an illusion

*Dr. Bernard Grossman is a practicing oncologist/hematologist and he is a member of Physicians for Social Responsibility. Correspondence may be addressed to Dr. Grossman, 408 Bellevue Avenue, Trenton, NJ 08628.

of security, actually is accompanied by an increase in actual danger and threat to life.

2. Image of the Enemy. Another concept that tends to foster old ways of thinking is an "image of the enemy." To prepare for war, a society must nurture hatred for its enemy. Once identified, all information obtained concerning the enemy is selected, distorted, and reflected in ways that validate the perception of the enemy's evil. The psychological term for this is "projection of the shadow." Clearly, President Ronald Reagan utilizes this imagery when he casts Moscow as "the focus of evil in the modern world." Nonetheless, this type of rhetoric is self-defeating and only serves to increase tensions between the superpowers.

3. Myth of Survivability. The myth of survivability through civil defense makes nuclear war palatable. While civil defense measures may have been appropriate for World War II, unfortunately, they no longer are meaningful in the nuclear age.

Evacuation and sheltering are the main components of civil defense. Evacuation is impractical for several reasons: a) missiles can be targeted to places of evacuation; b) impracticality of an organized plan; and c) lack of time to complete evacuation procedures. Shelters offer no more hope for survival than evacuation. People who reach shelters following a blast already would have received lethal radiation doses. They merely would enter the shelters and die. In the unlikely event that a shelter could be reached before a blast occurred, it would serve as a crematorium—unable to provide protection against the resulting blast, heat, radiation, and fire storms.

As evacuation and sheltering are unable to protect the citizenry during a nuclear attack, it would seem pure folly to endorse any portion of President Reagan's plans which have included evacuation to the country and filling out change of address forms for mail forwarding.

THE BEGINNINGS OF CHANGE

Once we accept that our old ways of thinking no longer are applicable in the nuclear age, we then are ready to accept new ways of thinking and the changes they will produce. Once realized, new ways of thinking can lead to assertive action. Each person—including physicians—can get involved in letter writing and phone campaigns or financial support of groups and candidates who espouse a mutually verifiable nuclear freeze. Physicians should encourage hospital administrations not to support the civilian-military contingency plan. As noted by Dr. Jack Geiger at a Physicians for Social Responsibility Conference in 1980, "Any physician who even takes part in a so-called emergency medical disaster planning—specifically to meet the problem of nuclear attack—is committing a profoundly unethical act. He is deluding himself or herself, colleagues, and, by implication, the public at large into the false belief that mechanisms of survival in any meaningful social sense are possible."

Writing letters to newspaper editors, participating in organized protests, joining Physicians for Social Responsibility, speaking out on radio talk shows, and stimulating discussion on the freeze issue are all positive, assertive responses which can lead to an increased chance of avoiding a nuclear confrontation. Through the ballot, representatives can be elected who recognize our current dilemma and who support an end to nuclear madness.

For its part, the government should continue to develop strong conventional forces to counteract threats to our own security or the security of our allies. Advancements of this kind effectively can neutralize numerical superiority the Soviets may have in Europe, for example. Improved communications and espionage networks can help preserve our security while not threatening the destruction of the world. While the abolition of all forms of war would be ideal, it is naive to think that this is possible in the foreseeable future and non-nuclear measures to ensure our security must be pursued.

Former Defense Secretary Robert S. McNamara has proposed a number of ways to reduce the chances of nuclear war: 1) a negotiated reduction in the ratio of nuclear warheads to missile launchers; 2) renouncing the strategy of launching on warning; 3) announcing a policy of no early first use of nuclear weapons; 4) strengthening NATO conventional forces; 5) redeploying our European missiles away from the Soviet border so as to make them less vulnerable to attack in the early hours of a conflict; 6) negotiate a nuclear freeze zone with the Soviets; 7) strengthen nuclear nonproliferation programs thereby limiting the growing membership of the world's nuclear club; and 8) negotiate the establishment of a joint U.S.-Soviet Information and Crisis Control Center. Even if a mutually verifiable freeze is not deemed feasible by the current administration, the above proposals certainly would be a move in the right direction.

Jonathan Schell summed up our choices in the final paragraph of his book, *The Fate of the Earth:* "Two paths lie before us. One leads to death, the other to life. If we choose the first path—if we numbly refuse to acknowledge the nearness of extinction, all the while increasing our preparations to bring it about—then we in effect become the allies of death, and in everything we do our attachment to life will weaken; our vision, blinded to the abyss that has opened at our feet, will dim and grow confused; our will, discouraged by the thought of trying to build on such a precarious foundation anything that is meant to last, will slacken; and we will sink into stupefaction, as though we were gradually weaning ourselves from life in preparation for the end. On the other hand, if we reject our doom, and bend our efforts toward survival—if we arouse ourselves to the peril and act to forestall it, making ourselves the allies of life—then the anesthetic fog will lift; our vision, no longer straining not to see the obvious, will sharpen; our will, finding secure ground to build on, will be restored; and we will take full and clear possession of life again. One day—and it is hard to believe that it will not be soon—we will make our choice. Either we will sink into the final coma and end it all or, as I trust and believe, we will awaken to the truth of our peril, a truth as great as life itself, and, like a person who has swallowed a lethal poison, but shakes off his stupor at the last moment and vomits the poison up, we will break through the layers of our denials, put aside our fainthearted excuses, and rise up to cleanse the earth of nuclear weapons."

Trustees' Minutes; UMDNJ Notes; AMNJ Report; Diagnostic Virology Report; Physicians Seeking Location in New Jersey

Trustees' Minutes March 18, 1984

A regular meeting of the Board of Trustees was held on Sunday, March 18, 1984, at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

Report of the President . . .
(1) Definition of Health Care Facility . . . Solicited opinions on a proposal of the State Department of Health to amend the definition of a health care facility for use at meeting of Dr. Kovacs with the Commissioner.
(2) New Jersey State Society of Anesthesiologists . . . Approved a resolution of appreciation to the New Jersey State Society of Anesthesiologists for their unrestricted grant of $1,000 to MSNJ.

Report of Executive Director . . .
(1) MSNJ 1984 Paid Membership . . . Noted that paid memberships as of February 29, 1984, totaled 6,420.
(2) MSNJ Financial Statements . . . Approved financial statements of MSNJ for period ending February 29, 1984.
(3) PRO Request for Proposal and Regulations . . . Noted that recently the Health Care Financing Administration (HCFA) released materials relative to request for proposal (RFP) for PRO contracts and regulations for the PRO program. The RFP requirements for Medicare waiver states (New Jersey is a "waived" state) were released in April.
(4) State Board of Medical Examiners . . .
(a) Proposed Regulation Regarding Dispensing Medication (N.J.A.C. 13:35-6.6) . . . Received Mr. Maressa's comment that the regulation was good from a risk prevention perspective. Also heard comments from Dr. Riggs, acting president of the State Board of Medical Examiners, that the rule applies to medications purchased by physicians in bulk and dispensed directly to patients. The proposed amendment requires that such medications be labeled with name of the dispenser, name of the patient, date when medication is dispensed, a description of the drug, and adequate instructions to the patient.
(b) Physical Examinations by Nurses . . . Received information from Dr. Riggs that the State Board of Nursing's recent memorandum instructing nursing schools to include in their curricula testicular, vaginal, bimanual pelvic, and rectal examinations was not acceptable; it would be in violation of the Medical Practice Act for a nursing physical examination to be used to arrive at a medical diagnosis and the Board of Nursing must inform professional schools and future licensees of the SBME's position.
(c) Corporate Practice of Medicine . . . Received information from Dr. Riggs on SBME's recent ruling on the corporate practice of medicine, which prohibits a nonphysician from hiring physicians to practice medicine. The ruling does not apply to hospitals and HMOs. When questioned if ruling applies to corporations formed by hospitals as nonprofit entities, Dr. Riggs said SBME had not considered this aspect; suggested Mr. Maressa request a ruling. Directed the executive staff to prepare a white paper on hospital corporate structures, their formation, and purpose, for the uninformed.
(5) Hospital Medical Staff Section . . . Voted to approve the establishment of a Hospital Medical Staff Section, to become an official Section of the Medical Society of New Jersey's House of Delegates, which shall remain functional during the entire administrative year and shall report to the Board of Trustees.

Committee on Medical Defense and Insurance . . . Considered all aspects of the current Legal Services Plan, heard Steven I. Kern, Esquire, report on the activities of the plan during 1983, and approved the following recommendation:

That the Legal Services Plan be continued in its present form, since it provides high-quality legal services at a modest expense to members of the Society.

Note: Dr. Riggs requested a postponement of action on the above recommendation until April so that he might respond in writing to Mr. Kern's report. Further consideration will be given to this matter at the April meeting. The Chairman of the Committee on Medical Defense and Insurance will be asked to attend the April meeting for additional input.

March Meeting of State Board of Medical Examiners . . . Received as informative, Trustee Dr. Fullerton's report of the March 14, 1984, meeting of the State Board of Medical Examiners, containing the following items on which Dr. Riggs commented:
(1) Termination of Pregnancy . . . Changed period in which abortions can be performed in a licensed and approved facility in the state of New Jersey to up to 18 weeks from last menstrual period.
(2) Senate Bill 111 . . . Opposed bill requiring a physician personally to present consent form for surgery to patient for signature. SBME urges MSNJ likewise to oppose this legislation.
(3) Flex Examinations . . . A total of 256 individuals took these examinations, of which 92 (36 percent) passed, 164 (64 percent) failed.

Old Business . . .
Medicaid Personal Physician Plan . . . Noted concern of William Silverman, M.D., of Atlantic County, relative to commitment made by chairman of the Committee on Medicaid in letter of December 14, 1983, to monitor all efforts of the Division of

Medical Assistance and Health Services, and fact that the Committee on Medicaid had not met since October. The Board's only comment was that the Committee would be meeting on April 25, 1984.

New Business . . .

(1) DRG Hearing . . . Noted that Congressman James J. Florio had extended an invitation to Camden County Medical Society to testify at a hearing before the U.S. House of Representatives' Select Committee on Aging's Subcommittee on Health and Long-Term Care on March 30 in Blackwood. Noted the purpose of the meeting is to assess New Jersey's experience with the DRG reimbursement system. Francis X. Keeley, M.D., of Camden County, and Alfred A. Alessi, M.D., cochairman of the Ad Hoc Committee on Presentation of MSNJ's DRG Position, will attend the meeting.

(2) Hospital Medical Staff Regulations . . . Considered fact that new constitution and bylaws at a local hospital were drafted by the hospital's attorney without prior input from the medical staff. Noted active membership on the medical staff is contingent upon physician's use of hospital facilities. Also, noted staff is directed to consult with its attorney to ascertain if MSNJ intervention is necessary and MSNJ will contact presidents of medical staffs, with copy to county medical societies, suggesting that each medical staff engage legal counsel. Directed that communication be sent to presidents of medical staffs urging them to elect a delegate to attend AMA Hospital Medical Staff Section meetings.

Note: This resulted from statements by Dr. Kristeller, chairman of the New Jersey Chapter, AMA Hospital Medical Staff Section, on fact that the AMA is developing a policy to allow medical staffs to have sole authority to select and remove its own officers, to set standards for medical staff patient care, and to establish and enforce criteria and standards for medical staff membership and clinical privileges. Medical staff bylaws would incorporate these principles, and the AMA's JCAH Commissioners would seek adoption of these points in the JCAH Accreditation Manual for Hospitals.

UMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

UMDNJ's new Cancer Research and Treatment Center in Newark is now open to treat patients with an advanced radiation therapy machine. The Center is staffed and equipped to handle all cancer patients who require radiation therapy. Previously, University Hospital patients needing such treatment had to be referred to other institutions, often to centers outside of New Jersey. Besides the treatment itself, the Center is capable of doing its own treatment planning and simulation.

In coming months, the highly specialized technique of surgically exposing tumors for direct radiation will be available for treating patients. Intraoperative radiation therapy, offered at few other places in the United States, enables massive doses of radiation to be applied directly to exposed tumor sites, without affecting skin, muscle, and other anatomy parts at risk in external radiation.

Two new key members of the UMDNJ-New Jersey Medical School faculty will play major roles at the Center: Stephen M. Stowe, M.D., chairman of radiation therapy, comes to UMDNJ from Children's Hospital of Los Angeles, where he was director of the Division of Radiation Oncology, and the University of Southern California School of Medicine, where he was an assistant professor in the departments of radiology and pediatrics; and Robert L. DeJager, M.D., director of medical oncology, was previously a member of the Cornell University medical faculty and thereafter director of clinical pharmacology at the Institute Jules Bordet, cancer center of the Free University of Brussels.

The Cancer Research and Treatment Center, which is open for treatment and consultation 8 A.M. to 4:30 P.M., Monday through Friday, uses an SL 75-20 linear accelerator, which dispenses radiation with extreme precision through a beam control system that minimizes damage to healthy surrounding tissue and organs. The accelerator processes and displays treatment regimens on a console incorporating a microprocessor and a video display unit.

The machine has four distinct radiation sources:

- An 8 million volt x-ray beam advantageous for treating deep-rooted cancers such as tumors of the pancreas or uterus.
- An 18 million volt x-ray beam useful for treatment that is particularly difficult because of the tumor's location and size, such as cancer of the cervix.
- Electron particle beams which, because they are less penetrating, are beneficial in treating skin and close-to-the-surface cancers and tumors around the head and neck, where the brain and spinal cord must be safeguarded.
- A special high-output beam intended principally for research but also useful for sterilizing blood and other products.

Information about the patient's cancer is programmed through the accelerator unit's treatment planning center to determine the best form of treatment. The validity of the computer's approach then is tested through the simulator, a facsimile of the linear accelerator.

More than 10 years in the planning and construction, the Cancer Research and Treatment Center, adjacent to University Hospital and the New Jersey Medical School on the Newark campus, will provide a statewide resource and referral facility specializing in the most difficult cancer cases and significantly will benefit the broad cancer research efforts already ongoing at the University. The Center offers new hope to the people of a state which has the fourth highest cancer death rate in the nation.

AMNJ Report

Paul J. Hirsch, M.D.
President

Plans are proceeding for the Academy of Medicine's Annual Awards Dinner. It will be held at the Chanticler in Short Hills; the date is Wednesday, May 23, 1984. Fellows of the Academy, friends, families, and colleagues will join us to honor the achievements of our Award recipients, and formally to install our new officers.

As a special feature of the dinner this year, the Academy of Medicine has commissioned an original work of art by noted artist, Richard Kemble. This will depict the famous

rinceton Battlefield Tree. An orig-
ıal signed and numbered copy will
e given to guests at the dinner.

As previously announced, Dr.
lfred A. Alessi will receive the Ed-
ard J. Ill Award for leadership in
ledicine. Congressman James
ourter will receive the Citizen's
ward for his multiple efforts on
ehalf of the health of the citizens of
ew Jersey. His particular interests
ave been liver transplants for chil-
ren, health care for the elderly,
ealth care for veterans, and re-
earch and treatment for victims of
lzheimer's disease.

New officers to be installed at the
inner are: Robert Rigolosi, M.D.,
resident; Dennis Filippone, M.D.,
resident-Elect; Arthur Krosnick,
.D., First Vice-President; and
nthony Minnefor, M.D., Second
ice-President. Dr. Benjamin Rush
ill serve as Secretary, and Dr. E.
harles Eckstein will serve as
reasurer for the forthcoming year.

The Academy of Medicine spon-
ored or cosponsored several major
mposia during April.

A symposium on "Management of
atients with Low Vision" was held
n Saturday, March 31, 1984, at
nd in cooperation with) Saint
arnabas Medical Center.

The Ninth Annual New Jersey Or-
opaedic Symposium was held on
riday and Saturday, April 6 and 7,
984. On Friday afternoon there was
conference on complications in or-
opaedic surgery, chaired by four
uest professors. That evening a
inner was given at the Hyatt Regen-
/ Hotel in New Brunswick, featur-
ıg Earl Ubell, Health and Science
ditor of WCBS-TV news, as the
ter-dinner speaker. His topic was
Ethical Questions Involving Or-
opaedic Surgery and the Media."
he symposium on Saturday, April
1984, was held at Rutgers Medical
chool from 8:00 A.M. until 4:30 P.M.
ixteen papers were presented.

A major symposium on "Current
erinatal Ultrasonography" was
eld at Newark Beth Israel Medical
enter on Saturday, April 14, 1984.
his program presented an update
r physicians in current techniques
f perinatal ultrasonography.

On Wednesday, April 18, 1984, a
mposium on "Substance Abuse
nd Misuse: An Update" was held at
ıe MSNJ headquarters building.
his program was cosponsored by
ıe Academy of Medicine and the
Medical Society of New Jersey.

Joseph Ruggles, our new As-
sociate Director for Continuing
Medical Education arrived at the
Academy in early April. We look for-
ward to his strong participation in
the process of continuing education
for physicians in New Jersey.

The 9th Annual Conference of the
Alliance for Continuing Medical
Education focused on the need for
organizations to help physicians in-
dividualize their educational pro-
grams, so as to be most pertinent to
their own practices. The following
were objectives: to agree upon a com-
mon definition of individualized
learning; to identify practical
methods of providing individualized
learning; to develop mechanisms by
which continuing medical educa-
tion (CME) providers may assist
physicians in planning their indi-
vidualized learning; to provide a
forum for discussion and exchange
of ideas among CME providers; and
to promote formation and support of
information networks among CME
provider colleagues.

This meeting provided a begin-
ning, to allow educators to become
comfortable with the concept of in-
dividualized tailoring of CME. The
keynote speaker pointed out that
the phrase "individual learning"
is redundant; all learning is done by
an individual. "Individualized learn-
ing" is little better; each individual
self-designs learning programs and
processes throughout life. The term
"individually tailored CME" was of-
fered as indicating the presence of a
standard process, focused on the
needs of the individual. These
semantic discussions served the
purpose of allowing the participants
to communicate with each other
about this concept.

Cost factors increasingly are im-
portant. Funding for hospital CME
programs is expected to diminish
under the federal DRG system.
These same factors may decrease
funds available to full-time phy-
sicians to attend educational pro-
grams which require travel. This will
reinforce the trend for education to
be closer to home.

To some extent, the concepts dis-
cussed require a transfer of re-
sponsibility for CME from the
educator to the learner. Providers
can help the physician to assess
educational needs, to identify educa-
tional activities, and to help plan
those activities. This will involve a
new process, one which will change
the relationship between the indi-
vidual physician and the educator,
and which is likely to enhance con-
tinuing education in medicine.

The participants agreed upon cer-
tain concepts, if not precise defi-
nitions. It is neither desirable nor
feasible for educational organiza-
tions to design an individualized
educational program for each phy-
sician. However, each physician nat-
urally designs an educational pro-
gram, by selecting what is read, what
meeting shall be attended, and what
new techniques shall be learned. Or-
ganizations can assist membership
by performing needs-assessment
surveys of various types, in order to
design programs which will meet
the needs of certain large and small
groups within the membership. "In-
dividualized CME" may include
counseling services provided by or-
ganizations, to help the individual
determine those programs and pro-
cesses which are most suitable to a
specific educational need.

Diagnostic Virology Laboratory, 1983, Saint Michael's Medical Center, Newark

Types and numbers of viruses isolated from specimens from north-
ern New Jersey metropolitan area are as follows:

DNA Viruses

Herpes simplex type 1 (oral strain)*	63
Herpes simplex type 2 (genital strain)	110
Varicella-zoster	2
Cytomegalovirus	18
Adenovirus (untyped)	3
Adenovirus 2**	4
Adenovirus 3	1
Adenovirus 5	1
Adenovirus 7	1
Adenovirus 16	3

RNA Viruses

Polio 2	2
Polio 3	4
Coxsackie A-9	3
Coxsackie B-1	7
Coxsackie B-4	2
Coxsackie B-5	5
Echo 5	1
Echo 9	1

*Monoclonal antibody determined. **Andeno and entero final I.D. by state laboratory at Trenton.

Clinical significance—As in all diagnostic virology laboratories, the most frequent viral isolate in 1983 was herpes simplex virus. The availability of good fluorescein-labeled monoclonal antibody in 1983 made strain identification easy. It can be seen that the genital strain was the most frequent isolate, about twice as many as the oral strain.

Many of the Cytomegaloviruses were isolated from AIDS victims, in whom this is one of the most common viral infections. The adenoisolates mainly were from children with respiratory syndromes. No influenza was isolated by our laboratory in 1983. The polio viruses represent probable vaccine strains from children. In 1983, the most common entero virus isolate was Coxsackie B-1. The number of echo viruses was low as compared to previous years when there were large numbers of Echo 9 and Echo 11.

Frank J. Michalski, Ph.D.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ALCOHOLISM—George W. Miller Jr., M.D., 77 Grove St., Apt. 8, Montclair, NJ 07042. UMDNJ 1980. Available July 1984.

ANESTHESIOLOGY—R.S. Saraiya, M.D., 88-25A 153rd St., Apt. 4-F, Jamaica, NY 11432. Baroda (India) 1978. Group or partnership. Available August 1984.

CARDIOLOGY—Aubrey Orrin Lewis, M.D., 200 Carman Ave., Apt. 21-F, East Meadow, NY 11554. SUNY-Syracuse 1979. Also, general internal medicine. Board certified (IM). Solo, partnership, group, academia (cardiology). Available July 1984.

FAMILY MEDICINE—Jaime F. Lara, M.D., 6045 Palisade Ave., West New York, NJ 07093. Seville (Spain) 1979. Board eligible. Partnership or institutionally based. Available.

Laurence Levenberg, M.D., 63 Harrowgate Dr., Cherry Hill, NJ 08003. SUNY-Upstate 1966. Group, partnership, solo. Available July 1984.

GASTROENTEROLOGY—Prakash V. Huded, M.D., 80-15 41 Ave., Apt. 606, Elmhurst, NY 11373. Karnatak (India) 1970. Board certified. Solo, group, partnership. Available.

H.L. Kirschenbaum, M.D., 780 Woolley Ave., Staten Island, NY 10314. New York Medical College 1977. Board eligible. Also, internal medicine. Partnership, group, full-time hospital. Available July 1984.

Mark F. Tsai, M.D., 1715 Stanford Dr., Columbia, MO 65201. National Taiwan University 1977. Also, internal medicine. Board certified. Available July 1984.

INTERNAL MEDICINE—Nicholas Bertini, M.D., 663 Hudson Ave., Albany, NY 12203. SUNY-Buffalo 1980. Board eligible. Group, partnership, solo. Available June 1984.

Palamadai S. Duraiswami, M.D., 64-A Oneida Ave., Centereach, NY 11720. Stanley Medical College (India) 1976. Board eligible. Available.

Z.U.A. Farooqui, M.D., Plaza Professional Bldg., Bayshore Rd. and Greenwood Ave., Box 238, Villas, NJ 08251. Aurangabad Medical College (India) 1972. Board eligible. Group or partnership. Available.

Elliott Friedman, M.D., 25 Penny La., Baltimore, MD 21209. SUNY-Syracuse 1978. Subspecialty, endocrinology. Board certified (IM); board eligible (M). Group or partnership (both specialties). Available July 1984.

Lee W. Hoffer, M.D., 1017 E. 80th St., Brooklyn, NY 11236. Rome (Italy) 1980. Solo, partnership, group. Available.

H.L. Kirschenbaum, M.D., 780 Woolley Ave., Staten Island, NY 10314. New York Medical College 1977. Board eligible. Also, gastroenterology. Partnership, group, full-time hospital. Available July 1984.

Quang T. Nguyen, M.D., 15 W. Englewood Ave., Bergenfield, NJ 07621. Saigon (South Vietnam) 1967. Subspecialty, nephrology. Boar eligible. Any type practice. Availabl July 1984.

Andrew L. Saporito, Jr., M.D., 2 Grandview Ave., West Orange, N 07052. Guadalajara (Mexico) 197(Group or partnership. Available.

Richard B. Schwarz, M.D., 8300 D Longpre Ave., Apt. 204, Los Angeles, C 90069. NYU 1979. Subspecialt nephrology. Board certified. Grou HMO, hospital. Available July 1984.

Gopal Shah, M.D., 100 Caton Ave., Ap 2-G, Brooklyn, NY 11218. M.R. Medic College (India) 1976. Board eligibl Group. Available July 1984.

Mark F. Tsai, M.D., 1715 Stanford Dr Columbia, MO 65201. National Taiwa University 1977. Also, gastroente ology. Board certified. Available Jul 1984.

M.S. Vafa, M.D., 10378 Gosport, Apt. 9 St. Louis, MO 63146. Ferdowsi 197 Subspecialty, radiology. Boar certified. Group or partnership. Avail able.

Steven Wolinsky, M.D., 1404 E. 15 St Brooklyn, NY 11230. Case Western Re serve 1980. Group or partnership Available July 1984.

NEPHROLOGY—Quang T. Nguyen, M.D 15 W. Englewood Ave., Bergenfield, N 07621. Saigon (South Vietnam) 1967 Also, internal medicine. Board eligible Any type practice. Available July 1984

Richard B. Schwarz, M.D., 8300 De Longpre Ave., Apt. 204, Los Angeles, C 90069. NYU 1979. Also, internal medi cine. Board certified (IM). Group, HMO hospital. Available July 1984.

OBSTETRICS/GYNECOLOGY—Balwan K. Chhatwal, M.D., 6416 Fairfield Ave. Berwyn, IL 60402. Delhi (India) 1975 Group, partnership, solo. Available July 1984.

Sheela Choubey, M.D., 1 Zirkel Ave. Piscataway, NJ 08854. Poona (India 1977. Board eligible. Group or partner ship. Available July 1984.

Atul S. Sheth, M.D., 2951 S. King Dr. Chicago, IL 60616. Specializing in in fertility, reproductive endocrinology Board eligible. Partnership, single o multiple-group practice, academia Available.

Ernest A. Topran, M.D., 3523 Dew berry-Southern Oaks, Shreveport, LA 71118. Louisiana State 1980. Group o partnership. Available July 1984.

PEDIATRICS—Dorothea H. Gross, M.D., 264 Boonton Turnpike, Lincoln Park, NJ 07035. Geneva (Switzerland) 1950. Clinic, group, emergency room, hospital, pharmaceutical research (salaried). Available.

Kusumam Sidharthan, M.D., 222 Yorkshire Ct., Old Bridge, NJ 08857. Calicut Medical College (India) 1976. Board eligible. Available July 1984.

PSYCHIATRY—Eric M. Levin, M.D., 43 West 8th St., Media, PA 19063. La Faculté Libre de Medicine (Spain) 1980.

Are You Moving?

If so, please send us your change of address, at least six weeks before you move.

Board eligible. Group, institutionally based, CMH outpatient. Available July 1984.

ULMONARY DISEASES—James Kohan, M.D., 19 Highmanor Dr., Henrietta, NY 14467. Virginia 1979. Also, general internal medicine. Board certified (IM). Group, partnership, solo, institutional. Available July 1984.

Dinesh Talati, M.D., 66-02 Grand Central Pkwy., Forest Hills, NY 11375. B.J. Medical College (India) 1974. Board eligible. Solo, group, partnership. Available July 1984.

ADIOLOGY/NUCLEAR MEDICINE—Conrad P. Erlich, M.D., 1243 Beacon St., Apt. 3B, Brookline, MA 02146. Boston 1976. Board certified. Group or partnership. Available July 1984.

Mindy M. Horrow, M.D., 131 Pond Brook Rd., Chestnut Hill, MA 02167. Medical College of Pennsylvania 1980. Board eligible. Group, HMO, academia. Available.

Subhash S. Pujara, M.D., Box 391B, Rt. 3, Andalusia, AL 36420. B.J. Medical College (India) 1969. Board certified (radiology); board eligible (nuclear medicine). Group, partnership, solo. Available.

M.S. Vafa, M.D., 10378 Gosport, Apt. 9, St. Louis, MO 63146. Ferdowsi 1973. Also, internal medicine. Board certified. Group or partnership. Available.

URGERY, GENERAL—Sara A. Case, M.D., 284 Quinby Rd., Rochester, NY 14623. Virginia 1975. Board eligible. Group—general surgery in moderate-sized city. Available August 1984.

Ruben J. Delgado, M.D., 7514 Oriental Tr., San Antonio, TX 78244. Puerto Rico 1976. Also, vascular surgery. Board certified. Single or multi-specialty group or solo. Available August 1984.

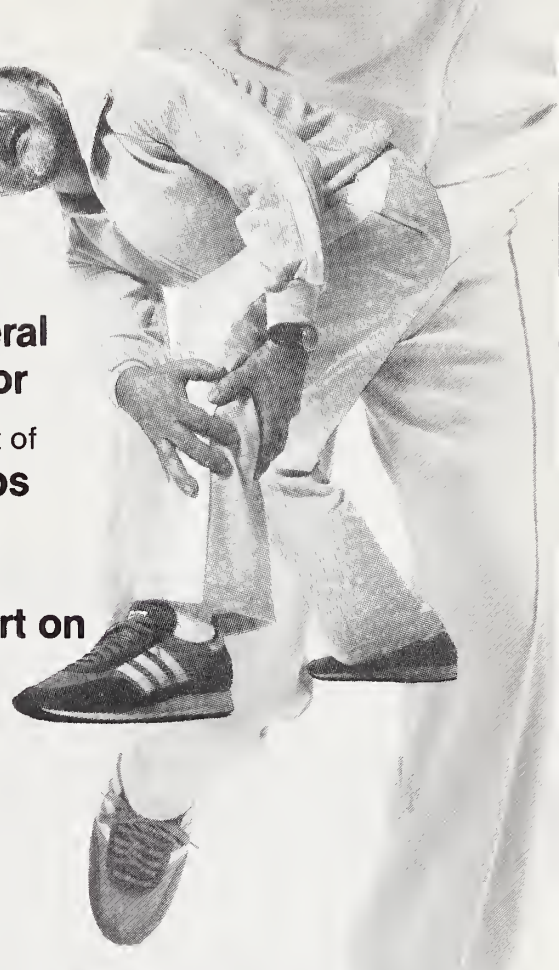
F. Andrew Morfesis, M.D., 7545 Rogers Ave., Upper Darby, PA 19082. Penn State (Hershey) 1979. Board eligible. Available July 1984.

James M. Stern, M.D., 600 Vista Court, Waynesboro, PA 17268. Jefferson 1958. Board certified. Solo, with freedom to practice in broad spectrum of surgery, including vascular and fractures. Available June 1984.

URGERY, ORTHOPEDIC—S.N. Saraiya, M.D., 88-125A 153rd St., Apt. 4-F, Jamaica, NY 11432. Baroda (India) 1974. Solo. Available August 1984.

URGERY, VASCULAR—Ruben J. Delgado, M.D., 7514 Oriental Tr., San Antonio, TX 78244. Puerto Rico 1976. Also, general surgery. Board certified (GS). Single or multispecialty group or solo. Available August 1984.

UROLOGY—Kiritkumar M. Pandya, M.D., 950 49th St., Apt. 9-A, Brooklyn, NY 11219. Baroda (India) 1970. Board eligible. Group, partnership, solo. Available.



A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release
LIPO-NICIN®/300 mg.

Each time-release capsule contains:
Nicotinic Acid .....300 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release
LIPO-NICIN®/250 mg.

Each yellow tablet contains:
Nicotinic Acid .....250 mg.
Niacinamide .....75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide .....75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN **THE BROWN PHARMACEUTICAL CO., INC.**
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

DO YOU LECTURE, TEACH, OR GIVE PRESENTATIONS?

Now available to you, the most effective modern visuals for any type of presentation you may give — from formal lecture to informal talks. We provide custom-designed materials for whatever your need at the most reasonable prices around. Our services include:

- 35mm slides
- slide/tape presentations
- overhead transparencies
- charts
- location photography
- graphics
- typesetting & printing

Also: Presentation Consultation, Meeting and Seminar preparation and Management.

Don't risk the effectiveness of your talk by ineffective, unprofessional visuals. For more information, call —

"The Media Store"
professionals for the professional **201-634-0048**

ACUPUNCTURE IN CLINICAL PRACTICE

N.Y. State Boards of Medicine & Dentistry 25-hour accredited seminar and workshop on the latest theories & techniques of manual and electro-acupuncture, applicable toward the 200-hour requirement for certification, will be given for licensed clinicians (with or without prior training) during the weekend of May 25-27, 1984 and again the weekend of July 6-8, 1984 at the Barbizon Plaza Hotel, New York City. Co-sponsored by the International College of Acupuncture & Electro-Therapeutics, its office journal, Acupuncture & Electro-Therap. Res., Int.J. (published by Pergamon Press and indexed in 15 major indexing periodicals; INDEX MEDICUS, etc.), the Heart Disease Research Foundation and the Neuroscience Dept. of Long Island College Hospital, Pharmacology Dept. of The Chicago Medical School. Also eligible for AMA/CME credit. For information, contract Y. Omura, M.D., ScD., 800 Riverside Drive (8-1), NYC 10032. Tel: (212) 781-6262 or (212) WA8-0658, or Saul Heller, M.D., Tel: (212) 838-7514.

ANNUAL AWARDS DINNER

of

THE ACADEMY OF MEDICINE OF NEW JERSEY

Wednesday, May 23, 1984
6:00 P.M.

at
THE CHANTICLER
Short Hills, New Jersey

1984 AWARD RECIPIENTS

EDWARD J. ILL AWARD
ALFRED A. ALESSI, M.D.

CITIZENS AWARD
CONGRESSMAN JAMES COURTER
(R-12th District)

SPECIAL RECOGNITION AWARD
SYLVAN E. MOOLTEN, M.D.

For further information, please contact:

The Academy of Medicine of New Jersey
Founded 1911

EXECUTIVE OFFICES
The Academy of Medicine of New Jerse
Two Princess Road
Lawrenceville, NJ 08648
(609) 896-1717

NEW JERSEY SOCIETY OF PATHOLOGISTS ANNUAL SPRING MEETING

SATURDAY, MAY 19, 1984
AT
UMDNJ-RUTGERS MEDICAL SCHOOL, PISCATAWAY, NJ
8:00 A.M.—2:00 P.M.
ON
"PRACTICAL APPLICATION OF LYMPHOCYTE TYPING FOR PATHOLOGISTS"

Program Chairman:
Stebbins B. Chandor, M.D.

The program is designed for pathologists to become familiar with recent advances in clinically relevant immunologic techniques which are of importance in the practice of pathology.

The objectives are to demonstrate ways in which newly developed immunological techniques may be utilized in the diagnosis of a variety of diseases with special emphasis on hematologic malignancies.

For further information contact:
Cathy Gillmer
Executive Secretary
New Jersey Society of Pathologists
Two Princess Road
Lawrenceville, New Jersey 08648
Phone: (609) 896-1717

June 16, 1984

4th Annual Advances in Gastroenterology

Golden Nugget Hotel
Atlantic City, New Jersey

Sponsored by the Gastrointestinal Section
of the Hospital of the
University of Pennsylvania
and
the Continuing Medical Education
Department of the
Underwood Memorial Hospital
Woodbury, New Jersey

Category 1 credit offered

Information: Registration Supervisor, SLACK Incorporated, 6900 Grove Road, Thorofare, New Jersey 08086, 609-848-1000

ME CALENDAR

The following is a list of continuing medical education courses for the next two months. Contact the sponsoring organization for further information.

is list is compiled through the coop-ation of the Committee on Medical lucation of the Medical Society of New rsey, the Academy of Medicine of New rsey, the New Jersey Chapter of the nerican Academy of Family Phy-cians, and the Office of Continuing edical Education of the UMDNJ. For formation on accreditation, please ntact the sponsoring organization(s), dicated by italics—last line of each em.

NESTHESIOLOGY

ne

4 Anesthesia Lectures
L 7-8 A.M.—NJ Medical School,
3 Newark
5 *(UMDNJ)*

5 Anesthesia Lectures
2 4-5 P.M.—NJ Medical School,
9 Newark
6 *(UMDNJ)*

6 Anesthesia Grand Rounds
3 4-5 P.M.—University Hospital,
0 Newark
7 *(UMDNJ)*

ARDIOLOGY

ne

6 Preventive Cardiology Seminar
0 12 noon-1 P.M.—NJ Medical School, Newark
(UMDNJ)

6 Vascular Conference
3 4-5 P.M.—NJ Medical School,
0 Newark
7 *(UMDNJ)*

6 Cardiac Arrhythmias
1-2:30 P.M.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

MEDICINE

June

1 Urology Grand Rounds
8 3-5 P.M.—NJ Medical School,
15 Newark
22 *(UMDNJ)*
29

1 Renal Conferences in Nephrology
15 4-5 P.M.—University Hospital, Newark
(Nephrology Society of NJ and Nephrology Section, AMNJ)

1 Grand Rounds in Rehabilitation
1:30-2:30 P.M.—Rotates between University Hospital, Newark, Kessler Institute, West Orange, and Children's Specialized Hospital, Westfield
(UMDNJ)

1 Dept. of Medicine Grand Rounds
8 11:30 A.M.-1 P.M.—NJ Medical
15 School, Newark
22 *(UMDNJ)*
29

6 Endocrine Conferences
13 3:30-5 P.M.—Rotates between
20 Newark Beth Israel Medical
27 Center, University Hospital, Newark, and United Hospitals Medical Ctr., Newark, and VA Medical Center, E. Orange
(Endocrinology Section, AMNJ)

6 Rehabilitation Medicine
13 4:15-5:15 P.M.—Kessler Institute,
20 West Orange
27 *(UMDNJ)*

6 Medical Grand Rounds
11:30 A.M.—VA Medical Ctr., East Orange
(Endocrinology Section, AMNJ)

6 Gastrointestinal Bleeding
1:30-2:30 P.M.—Essex County Hospital, Cedar Grove
(Essex County Hospital and AMNJ)

6 Therapeutic Controversies in GI Diseases
1:30-5 P.M.—Saint Barnabas Medical Ctr., Livingston
(NJ Gastroenterological Society and AMNJ)

6 Common Allergy Problems
20 Inflammatory Bowel Disease
1:30-2:30 P.M.—Rutgers Community Health Plan, 57 U.S. Hwy. 1, New Brunswick
(Rutgers Community Health Plan and AMNJ)

7 Digestive Disease I
14 8-9 A.M.—NJ Medical School,
21 Newark
28 *(UMDNJ)*

7 Digestive Diseases II
14 9-10 A.M.—NJ Medical School,
21 Newark
28 *(UMDNJ)*

7 Allergy, Immunology Lecture
14 11 A.M.-12 noon—Children's
21 Hospital, Newark
28 *(UMDNJ)*

7 Management of Short Stature
9 A.M.—Freehold Area Hospital
(AMNJ)

7 Medical Grand Rounds
9:30 A.M.—Newark Beth Israel Medical Center
(Endocrinology Section, AMNJ)

7 Irritable Bowel Syndrome
11 A.M.—St. Joseph's Hospital and Medical Center, Paterson
(St. Joseph's Hospital and Medical Center and AMNJ)

8 Medical Grand Rounds
11:30 A.M.—UMDNJ-University Hospital, Newark
(Endocrinology Section, AMNJ)

12 Fluid and Electrolyte Imbalance
11 A.M.-12 noon—Greystone Park Psychiatric Hospital
(Greystone Park Psychiatric Hospital and AMNJ)

14 Rheumatology Update
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

19 Continuous Arteriovenous Hemofiltration
4-5 P.M.—Academic Health Science Center, New Brunswick
(UMDNJ and AMNJ)

19 IVP Conference
5-7 P.M.—East Orange VA Hospital
(UMDNJ)

20 Interhospital Rheumatology Rounds
4:30-6 P.M.—University Hospital, Newark
(UMDNJ)

20 Pathogenesis, Diagnosis, and Management of Type II Diabetes
1-2:30 P.M.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

20 Dermatological Conference
6-9 P.M.—Rutgers Community Health Plan, 57 U.S. Hwy. 1, New Brunswick
(UMDNJ and AMNJ)

20 Cancer of the Colon
27 Diabetes Mellitus
10:30-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

20 Gastroesophageal Reflux
27 Peptic Ulcer Disease
8-9 A.M.—Elizabeth General Medical Center
(Elizabeth General Medical Center and AMNJ)

20 Chronic Liver Disease
9-10 A.M.—Elizabeth General Medical Center
(Elizabeth General Medical Center and AMNJ)

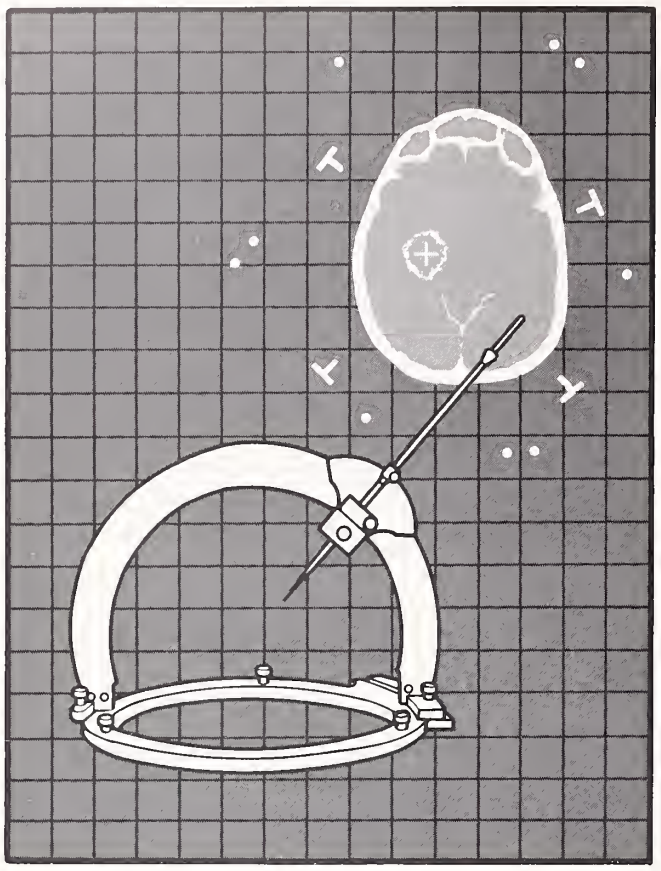
NEUROLOGY/PSYCHIATRY

June

1 Psychiatric Lecture Series
8 1:30-5 P.M.—Trenton Psychiatric
15 Hospital
(Trenton Psychiatric Hospital and AMNJ)

4 Depression in a Patient
8:15-10:30 P.M.—1046 So. Orange Ave., Short Hills
(Essex Psychiatric Seminar and AMNJ)

4 Psychotherapies
11 Psychotherapies
25 Behavior Modification
1-3 P.M.—Ancora Psychiatric



BRAIN TUMOR SYMPOSIUM:

ADVANCES IN DIAGNOSIS AND MANAGEMENT OF CEREBRAL GLIOMAS

Saturday, June 9, 1984, 8:30 A.M.—12 Noon

Alumni Hall, 2nd Floor, New College Building
Hahnemann University, 15th and Vine Streets
Philadelphia, Pennsylvania

Sponsored by

THE HAHNEMANN BRAIN TUMOR PROGRAM

An interdisciplinary treatment and research program of the Hahnemann Departments of Diagnostic Radiology, Hematology/Oncology, Neurology, Neurosurgery, and Radiation Oncology

in collaboration with

The Wistar Institute for Anatomy and Biology

HU

HAHNEMANN UNIVERSITY
SCHOOL OF MEDICINE
PHILADELPHIA, PENNSYLVANIA

Symposium Chairman:
Perry Black, M.D.
Department of Neurosurgery
Hahnemann University Hospital
(215) 448-8072

AMA approved: Category I Fee: $20.

Hospital, Hammonton
(Ancora Psychiatric Hospital and AMNJ)

Grand Rounds in Psychiatry
10:30 A.M.-12 noon—NJ Medical School, Newark
(UMDNJ)

Psychoneuroimmunology
9:30 A.M.-5 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

Group Therapy
2-3 P.M.—Ancora Psychiatric Hospital, Hammonton
(Ancora Psychiatric Hospital and AMNJ)

Management of Pain
8-9 A.M.—Elizabeth General Medical Center
(Elizabeth General Medical Center and AMNJ)

Spinal Opiate Therapy in Chronic Cancer Pain
9-10 A.M.—Elizabeth General Medical Center
(Elizabeth General Medical Center and AMNJ)

Calcium Channel Blockers in the Brain

Adolescents and Families with Drug and Alcohol Problems
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

Problem Behaviors in Adolescence
8 A.M.-3:30 P.M.—NJ Medical School, Newark
(UMDNJ, NJ Council of Child and Adolescent Psychiatry, and AMNJ)

Problem Behaviors in Adolescence
8 A.M.-3:30 P.M.—NJ Medical School, Newark
(UMDNJ, NJ Council of Child and Adolescent Psychiatry, and AMNJ)

Patient Compliance: Treatment Issues
1-2:30 A.M.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

Principles of Child Psychotherapy
8:30-10:30 P.M.—301 Broad Ave., Englewood
(NJ Psychoanalytic Society and AMNJ)

Lecture in Psychiatry
10:30 A.M.-12 noon—NJ Medical School, Newark
(UMDNJ)

Psychiatry Lecture
1-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(UMDNJ)

Update of Clinical Psychiatry
12 noon-4:30 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

The Many Faces of Clinical Depression
5-6:30 P.M.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

July

2 **Behavior Modification**
9 1-3 P.M.—Ancora Psychiatric
16 Hospital, Hammonton
23 *(Ancora Psychiatric Hospital and AMNJ)*

5 **Basic Neurological Principles for Neuropsychiatrists**

12 **Significance of Headache in Clinical Psychiatry**

19 **Treating the Remarried, Those Living Together, and Their Families**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

19 **Family and Couple Therapy**
12 noon-4:30 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

PATHOLOGY

June

13 **Pathology Grand Rounds**
10:30-12 noon—St. Mary's Hospital, Passaic
(St. Mary's Hospital and AMNJ)

14 **Pathology Seminar**
12 noon-1 P.M.—NJ Medical School, Newark
(UMDNJ)

PEDIATRICS

June

1 **Advances in Pediatrics**
8 9:30-10:30 A.M.—NJ Medical School,
15 Newark
22 *(UMDNJ)*
29

8 **AIDS in Children**
8-9:30 A.M.—Overlook Hospital, Summit
(Overlook Hospital and AMNJ)

9 **Problem Behaviors in Adolescence**
8 A.M.-3:30 P.M.—NJ Medical School, Newark
(UMDNJ, NJ Council of Child and Adolescent Psychiatry, and AMNJ)

18 **Practical Aspects of Pediatric Toxicology**
12 noon-1 P.M.—The Mountainside Hospital, Montclair
(The Mountainside Hospital and AMNJ)

RADIOLOGY

June

6 **Radiology Grand Rounds**
20 2-4 P.M.—University Hospital, Newark
(UMDNJ)

13 **Diagnosis of Biliary Tract Disease**
8-9 A.M.—Elizabeth General Medical Center
(Elizabeth General Medical Center and AMNJ)

27 **CT Conference**
4-6 P.M.—University Hospital, Newark
(UMDNJ)

July

2 **Basic, Advanced, and Real-Time,**
3 **Cross-Sectional Sector Scanning**
4 9 A.M.-5 P.M.—Sands Hotel, Atlantic
5 City
6 *(The National Foundation for Non-invasive Scanning and AMNJ)*

SURGERY

June

2 **Surgical Morbidity and Mortality**
9 **Conference**
16 8:30-10 A.M.—NJ Medical School,
23 Newark
30 *(UMNDJ)*

4 **Surgical Grand Rounds/Lecture**
11 **Series**
18 4:30-5:30 P.M.—NJ Medical School,
25 Newark
(UMDNJ)

6 **Surgical Departmental**
13 **Conference**
20 8:30-10 A.M.—Rutgers Medical School, Medical Education Bldg., New Brunswick
(UMDNJ and AMNJ)

SURGICAL SPECIALTIES

June

1 **Cancer Research Colloquium**
8 12 noon-1 P.M.—University
15 Hospital, Newark
22 *(UMDNJ)*
29

2 **Surgical Treatment of Cardiothoracic Diseases**
10-11:30 A.M.—NJ Medical School, Newark
(UMDNJ)

4 **Tumor Conference**
11 8-9 A.M.—University Hospital,
18 Newark
25 *(UMDNJ)*

7 **Vascular Surgical Rounds**
14 4-5 P.M.—Rutgers Medical School,
21 Medical Education Bldg., New
28 Brunswick
(UMDNJ and AMNJ)

13 **Ischemic Diseases of the Bowel**

27 **Surgical Treatment of Peptic Ulcer Disease**
9-10 A.M.—Elizabeth General Medical Center
(Elizabeth General Medical Center and AMNJ)

19 **Surgical Treatment of Morbid Obesity**
12 noon—St. Mary's Hospital, Orange
(AMNJ)

20 **Eye Institute Grand Rounds**
7-9 P.M.—United Hospital Annex Bldg.
(UMDNJ)

21 **Neurosurgery Lecture**
4-5 P.M.—University Hospital, Newark
(UMDNJ)



More people have survived cancer than now live in the City of Los Angeles.
We are winning.

Please support the

AMERICAN CANCER SOCIETY®

Clinical Nuclear Medicine; Computerizing Your Medical Office; Current Therapy in Obstetrics and Gynecology II; Illustrated Computer Tomography; Nuclear Magnetic Resonance; Pacemaker Therapy

Clinical Nuclear Medicine

M.N. Maisey, K.E. Britton, D.L. Gilday (eds). Philadephia, PA, W.B. Saunders, 1983. Pp. 525. Illustrated. ($60)

This condensed work, to which the contributors are physicians from the British Commonwealth as well as from the United States, adopts a different approach from other texts. Its emphasis rests less on interpretative skills and more on clinical correlation and differential diagnosis. The authors review a broad spectrum of topics, ranging from the organ systems, e.g. cardiac, respiratory, and neurological, to subjects of special consideration, such as pediatric nuclear medicine.

The chapter on respiratory disease, for example, reviews basic science and then moves on to the theory behind ventilation/perfusion scanning in embolic disease; the discussion includes a related section on deep-vein thrombosis. Applications of nuclear medicine in bronchiogenic carcinoma are discussed as are other diseases. A short description of the technique of administration and control standards is included.

This text will not enable one to interpret scans. However, it is a companion text which will augment the physician's understanding of the nuclear images.

Neil B. Horner, M.D.

Computerizing Your Medical Office: A Guide for Physicians and Their Staff

Dot Sellars. Oradell, NJ, Medical Economics Books, 1983. Pp. 228. ($11.50)

Dot Sellars's book is one of the "how-to-automate" books. Such books recently have appeared for novice purchasers of small business computer systems.

Sellars, a medical office administrator, does a good job in addressing specific needs for physician office automation. I give the book high grades for both readability and practicality. The reader must be aware that the book addresses minicomputer-based medical billing systems, not home computers with medical billing software.

A skillful layout makes the book easy to read and follow because the author writes in the terminology of the medical office; the reader will not have to consistently refer to the glossary. The book is divided into three major sections: Do you need a computer? How to get the right computer for your office? Making the computer do everything you want? Without a doubt these are the basic questions which potential purchasers want answered and Sellars's answers are practical.

Use of specific guidelines makes the answers both practical and reassuring for the novice. For example, Sellars presents an itemized guideline that allows the novice to reflect on the office's need for computer support. Another practical guideline is the steps to follow in shopping for a computer. I also strongly support the suggestions on employee involvement in the computer selection process. I am certain that a novice purchaser will benefit from the hand-holding these guidelines provide.

For anyone starting a first-time computer effort I recommend Sellars's book. Following her recommendations will ensure good value for the money invested.

James W. Allen, M.D.

Current Therapy in Obstetrics and Gynecology II

Edward J. Quilligan, M.D. Philadelphia, PA, W.B. Saunders Company, 1983. Pp. 320. Illustrated. ($32.50)

The second edition of this popular text has enlisted a new group of authors to give the reader a spectrum of opinions about a given topic. The chapters cover the fields of obstetrics and gynecology and include such general medical and surgical problems as hyperalimentation and atelectasis. The pathogenesis and treatment of each condition under discussion briefly is elucidated and often contains valuable insights and treatment suggestions that reflect the experience and expertise of the contributor.

Some shortcomings must be mentioned: A chart on antepartum fetal heart rate monitoring recommends a tracing be performed every two weeks, when what is meant is twice a week. The same figure suggests a tracing every two to three weeks if repetitive variable decelerations occur. Most practitioners would employ weekly or semi-weekly testing. There is some ambiguity in the chapter on female sterilization when in one paragraph coagulation of the Fallopian tube at a distance of 1 cm from the cornual insertion is recommended, while coagulation at least 3 to 4 cm from the cornua is suggested two pages later.

Overlapping of topics always is a problem in any text with multiple contributors. That a book with 120 contributors has such little duplication is a tribute to the skill of the editor. The text is weighted toward obstetrics, reflecting the advances in that field. The book may be recommended for the resident or attending physician who desires a brief updating of a particular problem. It would make a great present for a graduating resident.

Gerard F. Hansen, M.D.

Illustrated Computer Tomography: A Practical Guide to CT Interpretations

Shinji Takahashi (ed). New York, NY, Springer-Verlag, 1983. Pp. 306. Illustrated. ($83)

This review monograph is divided into four sections: a concise technical review, a short atlas, representative clinical vignettes, and a discussion on application in radiotherapy.

The technical summary is one of the more concise. The atlas is composed of well-illustrated drawings; however, the corresponding CT images are of a poorer quality. The section entitled, "Computed Tomography of Disease," has representative case studies which are examined in a very systematic manner conducive to a good comprehensive understanding of each case. The book's final chapter is devoted to the application of computed tomography in radiotherapy and attempts to touch base with the important aspects.

This is a short book for what it attempts. More space should have been devoted to the case studies and less to the technical aspects. It is recommended for the nonradiologist who wishes insight into the interpretative process of computer tomography.

Neil B. Horner, M.D.

Nuclear Magnetic Resonance (NMR) Imaging.

C. Leon Partain, A. Everette James, F. David Rollo, Ronald R. Price. Philadelphia, PA, W.B. Saunders Company, 1983. Pp. 592. ($75)

With the recent interest in nuclear magnetic resonance (NMR) imaging has come a multitude of texts such as the one edited by these researchers at Vanderbilt University. It stands in the middle between books that rely on higher mathematics and the basic introductory texts and uses clear language.

The goal of this book is to touch base with almost all areas of NMR without complicated equations. Selected topics include topical NMR analysis and superconducting magnetics. Included are results from clinical research sites, e.g., Massachusetts General Hospital. These are of interest, but clearly are dated; this section is the only weak point of the book.

This work is considered to be one of the better introductory texts and is geared for those with some higher mathematics. It deserves a place on the shelf of physicians with a serious interest in NMR imaging.

Neil B. Horner, M.D.

Pacemaker Therapy

Leonard S. Dreifus, M.D., (ed). Philadelphia, PA, F.A. Davis Co., 1983. Pp. 287. Illustrated. ($45)

This superb book is remarkably up to date for a medical text. Unfortunately, its audience appeal will be very limited because of many highly technical contributions that will unnerve even the most sophisticated pacemaker maven. For example, how many of our readers are aware that today's pacemakers have multiprogrammable antitachycardia features and telemetry and that they can store patient information and act as Holter monitors? Some modern pacemakers are so intelligent that they can be "interrogated" only by computers!

Like most other multiauthored texts, this one suffers from the overlap-repetition syndrome as well as considerable unevenness in the factual display. Some chapters, such as those devoted to the radiology pacemakers and the ECG analysis pacemaker function, offer a enormous amount of informati concisely, while others disturbing are skimpy or overtechnical. An e ample of the latter is, "Availab Types of Pacemakers," where ev the authors conclude that keepi track of all the options on mode pacemakers is as difficult as listi those available on a "modern luxu sedan." Similar high-tech chapte include "Pacemaker Implantatio "Programmable Pacemakers," a "Pacing Leads."

Steiner and Tegtmeyer present very valuable treatise on the rad logic aspects of normal and a normal pacemaker function. The f ures, mostly plain films, are supe and the appendix of radiopaq identification codes is a must every active pacemakernik.

Barold et al. offer a huge and d ficult discussion on the EC analysis of pacemaker functio This cannot be handled in a p functory manner, for terms li pseudofailure, pseudocapture, f sion, pseudofusion, and pseud pseudofusion will perplex even t master electrocardiographer.

Contributions by Wellens et and by Berkovits et al. deal with t relatively new role of pacing in t treatment of the tachycardias. The chapters are readable and pithy.

While some of the authors prese pot-boiling rehashes, others, such Mirowski's, "Automatic Implantab Defibrillator," and Berkovits's "F ture Generation Pacemakers," pre ent exciting, new ideas.

Despite some shortcomings, th multiauthored text is clearly "sta of the art."

Edwin L. Rothfeld, M.

BITUARIES

Drs. Azzara; Bernstein; Block; Farmer; Greenfield; Hermann; Kubes; Metzer; Nobile; and Stutchin

:. Emanuel S. Azzara

Word has been received of the ath of Emanuel S. Azzara, M.D., a mber of our Mercer County com- nent. Born in 1896, Dr. Azzara ned his medical degree at Tulane iversity School of Medicine, Lou- ana, in 1924. A family practi- ner, Dr. Azzara was affiliated with nterdon Medical Center. He was nember of the American Medical sociation.

:. Ellen H. Bernstein

At the untimely age of 46, Ellen H. nstein, M.D., died on February 1984. An ophthalmologist, Dr. nstein had a private practice in zabeth for 13 years. Dr. Bernstein eived her medical degree from w York University School of Medicine in 1963. A member of our Union County component, Dr. Bernstein was a Diplomate of the American Board of Ophthalmology and a member of the American Medical Association. During her career, Dr. Bernstein was affiliated with two Elizabeth hospitals: General Hospital and St. Elizabeth.

Dr. Paul J. Block

Paul J. Block, M.D., a member of our Monmouth County component, died on February 7, 1984. Born in 1938, Dr. Block earned his medical degree from New York University School of Medicine in 1964. A cardiologist, Dr. Block was affiliated with Monmouth Medical Center, Long Branch, Freehold Area Hospital, and Bayshore Hospital, Holmdel. A Diplomate of the American Board of Internal Medicine, Dr. Block was a Fellow of the American College of Cardiology.

Dr. Walter D. Farmer

At the grand age of 84, Walter David Farmer, M.D., died on February 7, 1984. He received his medical degree from McGill University, Canada, in 1926. Dr. Farmer was a family practitioner affiliated with Mercer Medical Center, Trenton. He was a member of our Mercer County component and of the American Medical Association, and a Fellow of the American Academy of Family Practice. In 1976, Dr. Farmer was a recipient of MSNJ's Golden Merit Award for 50 years of service to the medical community.

Dr. Arthur W. Greenfield

At the grand age of 85, Arthur William Greenfield, M.D., died on February 25, 1984. Dr. Greenfield received his medical degree from the University of Minnesota in 1925. He was a member of our Bergen County component and of the American Medical Association. For 40 years, Dr. Greenfield had a private family practice in Hackensack and was affiliated with Hackensack Medical Center.

Dr. John H. Hermann

John Herbert Hermann, M.D., a retired member of our Essex County component, died on January 12, 1984. Dr. Hermann was born in 1891 and received his medical degree from New York University School of Medicine in 1914. During his career, Dr. Hermann was affiliated with St. Mary's Hospital, Orange, and was a member of the American Medical Association.

Dr. Zdenek Kubes

Word has been received of the death of Zdenek Kubes, M.D., a member of our Essex County component. Dr. Kubes was born in 1912 and was awarded a medical degree from Masaryk University, Czechoslovakia, in 1937. Dr. Kubes, an obstetrician-gynecologist, was affiliated with Bayonne Hospital, Greenville Hospital, Jersey City, and Newark City Hospital. He was a member of the American Medical Association and a Fellow of the American College of Surgeons.

Dr. Freeman W. Metzer

Freeman Weeks Metzer, M.D., died on February 5, 1984. Born in 1904, Dr. Metzer earned a medical degree at the University of Pennsylvania School of Medicine in 1931. A surgeon, Dr. Metzer was affiliated with Zurbrugg Memorial Hospital, Riverside. Dr. Metzer was a member of our Burlington County component and of the American Medical Association, and was a Fellow of the American College of Surgeons.

Dr. James J. Nobile

At the age of 74, James John Nobile, M.D., a member of our Hudson County component, died on January 24, 1984. Dr. Nobile was an internist in Hoboken since 1938, and was affiliated with St. Mary's Hospital. Dr. Nobile was a graduate of Georgetown University Medical School in 1935. A member of the American Medical Association, Dr. Nobile was a Fellow of the American College of Chest Physicians.

Dr. Abe D. Stutchin

On January 30, 1984, Abe David Stutchin, M.D., died. Born in 1922, Dr. Stutchin received his medical degree from Yeshiva Medical School, New York, in 1959. A member of our Passaic County component and of the American Medical Association, Dr. Stutchin was a family practitioner. He was affiliated with St. Joseph's Hospital and Medical Center, Paterson, during his 24-year career.

Style Sheet

The Journal *is the official organ of the Medical Society of New Jersey. The goals of* The Journal *are educational and informational. All material published in* The Journal *is copyrighted by MSNJ.*

CONTENT

The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports based on unusual clinical experiences; review articles; clinical notes, succinct items on some aspect or new observation or technique of a case experience; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update; and an opinion column. Editorials are prepared by the Editor and by guest contributors on timely and relevant subjects; editorials are the responsibility of the author. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the Editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made in New Jersey.

ASSIGNMENT OF COPYRIGHT

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978), a transmittal letter or a separate statment accompanying material offered to *The Journal* of the Medical Society of New Jersey must contain the following language and must be signed by all authors:

"In consideration of *The Journal* of the Medical Society of New Jersey taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *The Journal*, MSNJ."

SPECIFICATIONS

Submit two **manuscripts** that must be typewritten and double-spaced on 8½" by 11" paper. Statistical methods used in articles should be identified. Acknowledgements will be made only for specific preparation of an essential part of the manuscript.

Authors are asked to seek clarity, accuracy, and originality; attention to details of grammar, spelling, and typing are important.

The **title page** should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

The author should submit a 40-word **abstract** to be used at the beginning of the article.

Tables must be typewritten and double-spaced on separate 8½" by 11" sheets, with a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source; written permission for r publication from the original pu lisher must be submitted. The cc of color photographs must be bor by the author.

Generic names should be us with proprietary names indicat parenthetically or as a footnote wi the first use of the generic nan Proprietary names of devices shou be indicated by the registration sy bol—®.

The **summary** of the article shou not exceed 250 words; it should cc tain only essential facts.

References should not exceed citations except in review articl and should be cited consecutively the text by numbers in parenthes at the end of the sentence. The ref ence list should be typewritten a double-spaced on separate 8½" 11" sheets in the numerical order which they are first cited in the te The style of reference is that of *Inc Medicus:*

1. Goldwyn RM: Subcutaneo mastectomy. *J Med Soc* 74:1050-1052, 1977.

2. Dixon WJ, Massey FJ: *Introd tion to Statistical Analysis.* N York, NY, McGraw-Hill, 1969, 42-48.

PUBLICATION POLICY

Receipt of each manuscript will acknowledged and a copy delive to the Editor who refers the pape one or more members of the E torial Board. The final decision is served for the Editor. No direct c tact between the reviewers and authors will be permitted, authors will be informed of the viewers' comments. The publicat lag for original articles may be months or more. Galley proofs be submitted to the author for c rection of typographical errors.

REPRINT ORDERS

Reprints may be ordered after author is notified that the art has been selected for a specific is of JMSNJ. A check for the cos reprints including remake charg order is received after due date m accompany the order.

COMMUNICATIONS

All communications should sent to the Editor, *The Jour* MSNJ, 2 Princess Road, L renceville, NJ 08648.

SEEKING
RADIOLOGY OFFICE PRACTICE

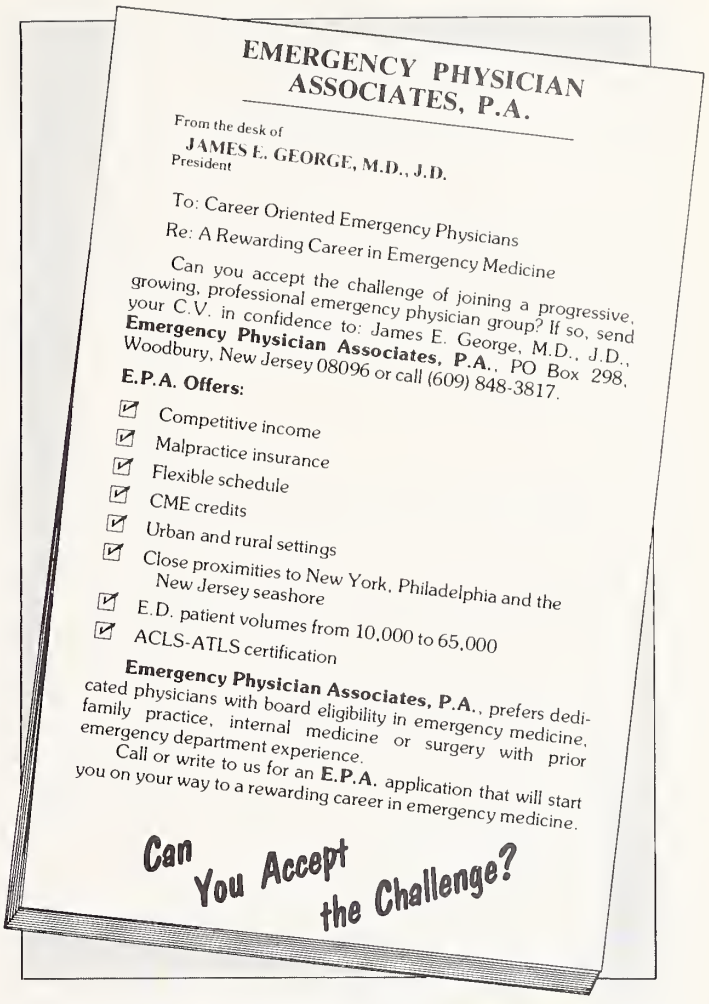
A Board Certified Radiologist with nine years hospital based experience is seeking to buy into or buy out an active private office radiology practice in Northern or Central New Jersey.

Write: Box No. 71 JMSNJ
Two Princess Road
Lawrenceville, NJ 08648

Associate Medical Director

South Jersey office, major national firm, seeks Associate Medical Director; part-time initially; eventual full-time career opportunity with competitive salary/benefits; requires sound professional background; experience, or substantial interest in utilization control/peer review/medical administration. Replies strictly confidential. Reply to:

Box No. 80
JMSNJ
2 Princess Road
Lawrenceville, NJ 08648



EMERGENCY PHYSICIAN ASSOCIATES, P.A.

From the desk of
JAMES E. GEORGE, M.D., J.D.
President

To: Career Oriented Emergency Physicians

Re: A Rewarding Career in Emergency Medicine

Can you accept the challenge of joining a progressive, growing, professional emergency physician group? If so, send your C.V. in confidence to: James E. George, M.D., J.D., **Emergency Physician Associates, P.A.**, PO Box 298, Woodbury, New Jersey 08096 or call (609) 848-3817.

E.P.A. Offers:

- ☑ Competitive income
- ☑ Malpractice insurance
- ☑ Flexible schedule
- ☑ CME credits
- ☑ Urban and rural settings
- ☑ Close proximities to New York, Philadelphia and the New Jersey seashore
- ☑ E.D. patient volumes from 10,000 to 65,000
- ☑ ACLS-ATLS certification

Emergency Physician Associates, P.A., prefers dedicated physicians with board eligibility in emergency medicine, family practice, internal medicine or surgery with prior emergency department experience.

Call or write to us for an **E.P.A.** application that will start you on your way to a rewarding career in emergency medicine.

Can You Accept the Challenge?

COORDINATOR OF MEDICAL AFFAIRS

"Progressive" is the Word at . . .

RIVERVIEW MEDICAL CENTER, a 500 bed acute care facility located in Red Bank, NJ on the Navesink River.

We are accredited by JCAH, NJ State Dept. of Health and NJ Hospital Association. Our affiliations include Brookdale Community College, Monmouth County Vocational School, Seton Hall University and Monmouth College.

This highly visible position will report directly to the President of the Medical Staff, Executive Committee of the Medical Staff and the Administrator.

The Coordinator, under the direction of the President of the Medical Staff, and in conjunction with the Medical Center Administrator, shall supervise the execution of the By-laws of the Medical Staff, the Rules and Regulations of the Medical Center, and all policies of the Board of Governors. The Coordinator of Medical Affairs shall insure the continuing excellence of patient care at Riverview Medical Center.

Interested candidates kindly submit your resume inclusive of vitae, licensure, salary history, qualifications and credentials to: Ms. Sharon K. Barrows, Personnel Recruiter.

RIVERVIEW MEDICAL CENTER
35 Union Street, Red Bank, NJ 07701
Equal Opportunity Employer M/F

GROUP PRACTICE OPPORTUNITIES

BC/BE Family Practitioners for expanding federally qualified HMO, serving 36,000 members from three delivery sites in Cosmopolitan South Jersey area. Congenial staff of 30 full-time physicians, and 75 to 100 contracting specialists covering all disciplines. Excellent hospital facilities. Medical school affiliation. Choice of pleasant living conditions in suburban, rural, or semi-rural communities. Superior schools. Easy access to Philadelphia (15 minutes), New York City (90 minutes), Jersey Shore (60 minutes), Jersey Pine Barrens (20 minutes) and Pocono Recreation Area (2 hours). Competitive salary and comprehensive benefit package.

Send Curriculum Vitae to Kenneth M. Carroll, M.D. Executive Vice President/Medical Affairs, Health Care Plan of New Jersey, 165 Old Marlton Pike, Medford, New Jersey 08055.

CLASSIFIED ADVERTISEMENTS

GENERAL PRACTITIONER—Semi-retired, age 55, desires industrial, pharmaceutical or similar position. (201) 545-4339.

INTERNIST—Board eligible, general internist with extensive emergency room experience. Seeking group practice of internal medicine or emergency room position. Northern NJ area. Available July 1984. Please call 212-645-4616, Steven Wolinsky, MD. Curriculum vitae and references available upon request.

OB-GYN—Board certified, 35, experienced, wants to relocate. Solo, group or partnership. Available immediately. Box No. 66, JMSNJ.

OB-GYN—Seeking group practice or partnership. Completing 4th year residency at Louisiana State University Medical Center, Shreveport, LA. New Jersey born and educated. Available July 1984. Call 318-686-2095 home or 318-674-5000 hospital.

RADIOLOGIST—Board certified, trained in general diagnosis, nuclear medicine, special procedures, CT and ultrasound. Available full or part-time. Group practice or hospital based, North or Central NJ. Write Box No. 81, JMSNJ.

NEEDED CARDIOLOGIST/INTERNIST—Cardiologist needed for multi-specialty Internal Medicine group in the South Jersey area near Atlantic City. Salary with eventual partnership. Excellent benefit package. If interested, please send curriculum vitae to Box No. 76, JMSNJ.

NEEDED FAMILY PHYSICIAN—Board eligible, for partnership in one of the largest family practice facilities in NJ. Please send resume to Box No. 69, JMSNJ.

NEEDED INTERNIST—With formal geriatric training or strong interest in geriatrics to join same in NJ practice approximately thirty minutes from Manhattan. Send CV to Box No. 82, JMSNJ.

NEEDED PEDIATRICIAN—A well established pediatric office in Southern New Jersey seeks a pediatrician-generalist or subspecialist as an Associate. Write Box No. 75, JMSNJ.

NEEDED PRIMARY CARE PHYSICIANS—Private fee-for-service practice in new, fully equipped suburban offices. All personal supplies and management services provided. This is an excellent opportunity for physicians with a good "bedside" manner interested in developing a lucrative practice and still desiring time for the pursuit of happiness. Reply to Neighborhood Doctor Corporation, 901 Long Beach Blvd., Ship Bottom, NJ 08008.

NEEDED PSYCHIATRIST—For private, multi-disciplined outpatient center near Plainfield-Fanwood border. Part or full time. Send CV to Bertram Warren, MD, Union County Psychiatric Clinic, 1358 South Avenue, Plainfield, NJ 07062.

PEDIATRICIAN/PRACTICE—Middle-age, board certified, planning to sell private practice. Seeks part-time position. Pediatric clinic or office. Prefer Monmouth or Ocean County. Willing to work nights and weekends. Write Box No. 73, JMSNJ.

WANTED—RADIOLOGY OFFICE PRACTICE—Board certified Radiologist with nine years hospital based experience is seeking to buy into or buy out an active private office radiology practice in Northern or Central NJ. Write Box No. 71, JMSNJ.

WANTED—RADIOLOGY PRACTICE—Interested in buying a radiology practice in NJ. Write Box No. 83, JMSNJ.

PRACTICE FOR SALE—General Medicine Practice, Central NJ, 45 minutes from NY. Blend of office-nursing home patients. Low overhead. Write Box No. 79, JMSNJ.

PRACTICE FOR SALE—OB-GYN, immediately in Northern Monmouth County near two accredited hospitals, in appealing residential community, will introduce. Call 201-264-7763.

PRACTICE SPECIAL OPPORTUNITY—Large beautiful office, fully furnished and equipped. Excellent location at bus stop and near hospital. Can serve 1 or 2 doctors, other health career personnel or other profession. Available due to physician's death. Patients waiting, contact Mrs. L. Friedman, 18th & Northampton Sts., Easton, PA 18042. 215-252-6341.

HOUSE/OFFICE FOR SALE—Edison, NJ. Immaculate 4 bedroom home set on a fully landscaped ½ acre with attached 5 room doctor's suite. Private entrance. Ample parking. Choice location near John F. Kennedy Medical Center. $189,900. Call 201-549-0600.

HOUSE/OFFICE FOR SALE—Short Hills. Ranch style home, 8 room, 3 baths, professional office suitable for medical office or lower level. $650,000, Telephone 201-376-7455, call after 5 p.m.

FOR SALE OR RENT—Kearny. Fully equipped and furnished medical office building including patients' records. Corner location on main street. Call after 8 p.m. 201-746-1709.

FOR SALE OR RENT—For immediate occupancy, new, modern, energy efficient building, 500 to 2,000 square feet available. 31,000 residents within three mile radius. Close to Philadelphia, Atlantic City, Central Jersey shore area. Internists and specialists needed. Ideal for main/satellite office. Call 201-350-1008.

FOR RENT—Fully equipped, furnishe physician's office just 18 miles west Atlantic City. Call 609-965-1600. Wri Mrs. Marie Frank, 227 Philadelphia Av Egg Harbor City, NJ 08215.

FOR RENT—Office space available fully equipped internist's office Berkeley Heights. Further informatic call 201-376-8511, 9 a.m.-5 p.m. M-F.

FOR RENT—Office space, Souther Gloucester Township, Camden Count Office suite in new medical buildin 1000 or 2000 square foot suites ava able. Located in rapidly growing, high desirable area, near several large hosp tals. Ideal for family practice or specialis Building to be completed late 1984. C Dr. Ribatsky 609-227-2221.

FOR RENT—Professional office space f rent. Millburn prestigious building, 77 square feet. On-site parking, on bu route. Call 201-731-1900.

FOR RENT—Professional office for rer approximately 710 square feet. Ne Dover General Hospital. Near route 8 and 46. Morris County, NJ. Telephor 201-366-2557.

FOR RENT—Professional office for rer furnished, located in the Ironbound se tion of Newark. Available July 1984. C 201-762-6781.

FOR RENT—Beautiful, completely fu nished medical office on Old Short Hil Road across from St. Barnabas Hospit Parking lot, 13.31 square feet. Lar waiting room, 3 examining rooms, co sultation room. Yours alone, no elevator A rare find. Write Box No. 84, JMSNJ

OFFICE FOR RENT OR SHARE—Spacious, furnished 600-1500 squa feet, ample parking. Hazlet-Holmdel ar close to hospital. Call 201-264-7763.

SUBLET SPACE—Office to sublet in pr fessional building. Deptford/Woodbur Call 609-853-8720.

OFFICE FOR SHARE—Hudson Coun at two locations near hospitals ar transportation. Call 201-864-7172.

OFFICE FOR SHARE—Morristown, ce tral location. Near hospital, ful equipped, newly decorated. All utiliti included. Ample parking available. Ne public transportation. Available immed ately. 201-267-2555.

OFFICE SPACE TO SHARE—101 O Short Hills Road, West Orange. Acro from St. Barnabas Hospita 201-994-9277.

OFFICE TO SHARE—Westfield, centr location. Near hospital, fully equipped a tractively decorated. All utilities include Ample parking available. Near publ transportation. Available immediatel 201-267-2555.

CLASSIFIED ADVERTISEMENTS

PACE WANTED—Professional office ace to share. Physician needs two days r week. Journal Square area, Jersey ty, NJ 201-684-5077.

SPACE WANTED—Family practice physician looking for office in Union County to share or rent. Please call Dr. K. Patel 201-344-1575.

FOR SALE—BOAT, 1982 Sea Ray Sedan, fly bridge, head, shower all extras. 26 foot by 10 foot. Call 201-864-7172.

ATE INFORMATION FOR MEMBERS: $5.00 per insertion up to 25 words; 10 cents each additional word. Payable in advance. **ORD COUNT:** Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of mbers, hyphenated words. Count name and address as five words, telephone number as one word, and "Write Box No. 000, o JMSNJ" as six words. **COPY DEADLINE:** Fifth of preceding month.

Seeking new patients?

we are
SPECIALISTS
in
PUBLIC RELATIONS
FOR THE MEDICAL PROFESSION
for a confidential interview call—
(201) 531-7080

phyllis kessel associates
780 West Park Avenue, Oakhurst, N.J. 07755

It's A Major Medical Explosion

The Lakewood, Toms River and Point Pleasant hospitals are all going ahead with major expansion programs . . . Bricktown to build new facility.

Cross River Professional Center
400 to 2,300 Square Feet
¼ Mile South of Kimball Medical Center

- $9 to $11 per square foot
- Graduated rent schedules
- Ownership options available
- Fully landscaped
- Centrally located and 10 minutes to three major hospitals
- Private entrances and all services available
- Equipment leases available

BARRYMOR ENTERPRISES Brokers Protected
1200 River Avenue (Route 9), Lakewood, NJ 08701 • (201) 367-2226

Wanted: Physicians who prefer medicine to paperwork.

We are looking for dedicated physicians, physicians who want to be, not salesmen, accountants, and lawyers, but physicians. For such physicians, we offer a practice that is practically perfect, where in almost no time you experience a spectrum of cases some physicians do not encounter in a lifetime, where you work without worrying whether the patient can pay or you will be sued, and where you prescribe, not the least care, or the most defensive care, but the best care.

If that is what you want, join the physicians who have joined the Army. Army Medicine is the perfect setting for the dedicated physician. Army Medicine provides wide-ranging opportunities for the student, the resident, and the practicing physician alike.

Army Medicine offers fully accredited residencies in virtually every specialty. Army residents generally receive higher compensation and greater responsibility than do their civilian counterparts and score higher on specialty examinations.

Army Medicine offers an attractive alternative to civilian practice. As an Army Officer, you receive substantial compensation, extensive annual paid vacation, a remarkable retirement plan, and the freedom to practice without endless insurance forms, malpractice premiums, and cash flow worries.

Army Medicine:
The practice that's practically all medicine.

FOR FURTHER INFORMATION CALL COLLECT:
1LT John J. Schafer, AMEDD Personnel Counselor, USA MEDDAC,
Fort Dix, NJ 08640 Phone: (609) 562-4271

An Equal Opportunity Employer

Need A Temporary Physician?

CompHealth treats your practice as if it were our own during: vacations, CMEs, recruiting, clinic start-up or other absences.

Want Free Time While You Practice Medicine?

Join CompHealth's Locum Tenens Physician Group.

★

For further information about temporary coverage or locum tenens practice opportunities, call:

CompHealth

A Physician Group

WILSON ROSS, Regional Administrator
244 East Hanover St.
Trenton, NJ 08608
Telephone: 609-392-1111

TAX SHELTERS

Just one of the personal financial services available to you from the ***physician's bank.***

- tax planning
- lines of credit
- equipment financing
- retirement planning

- money management
- cash flow • investments

- estate planning

Call or Write

Joseph J. Verbaro, Jr.
Senior Vice President
(201) 228-9770

FINTRUST

FINANCIAL AND TRUST SERVICES

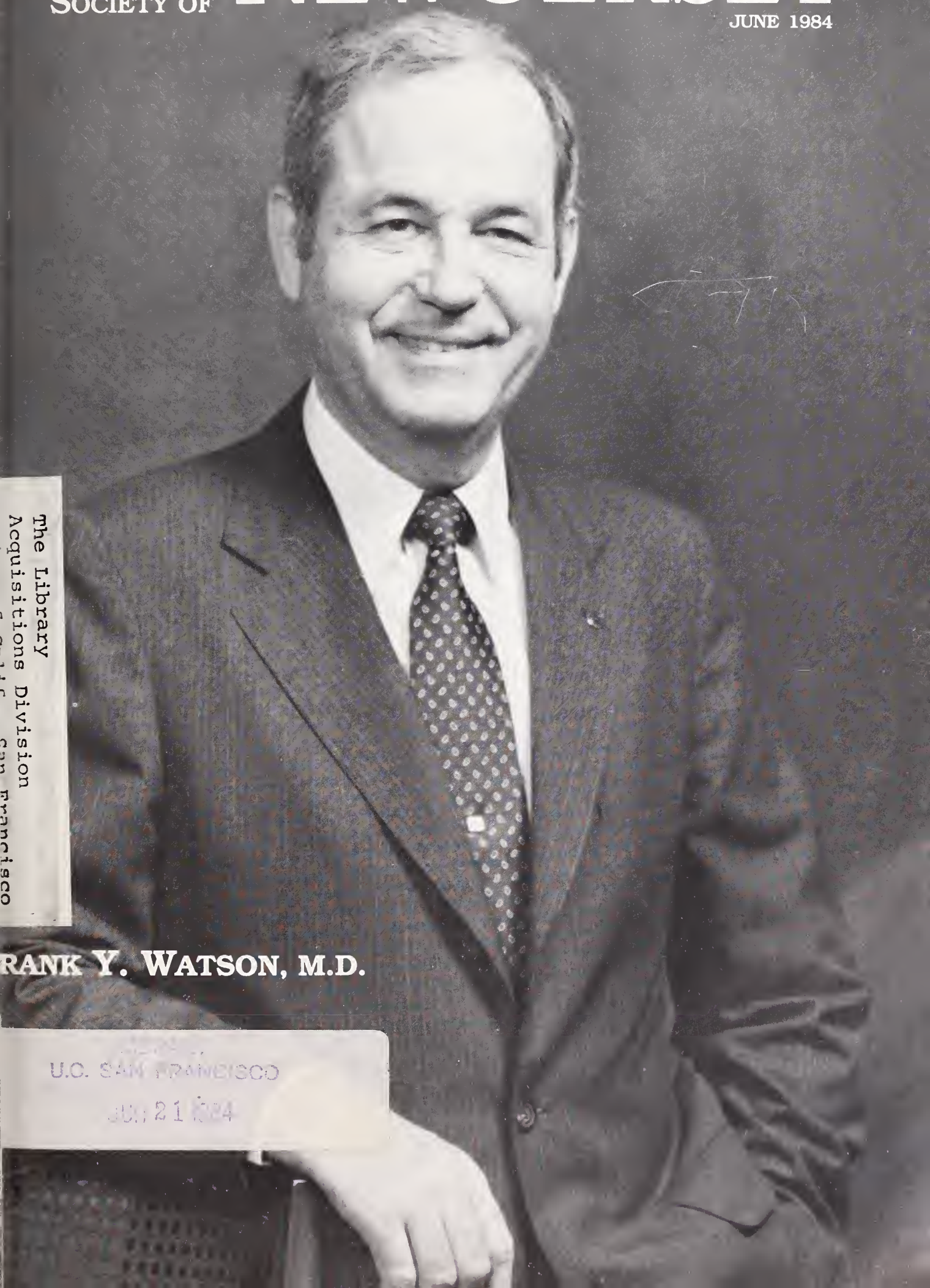
DIVISION OF SECURITY NATIONAL BANK & TRUST COMPANY OF NEW JERSEY

101 Eisenhower Parkway
Roseland, New Jersey 07068 Member F.D.I.C.

THE JOURNAL OF THE MEDICAL SOCIETY OF

NEW JERSEY

JUNE 1984



The Library
Acquisitions Division

RANK Y. WATSON, M.D.

U.C. SAN FRANCISCO
JUL 21 1984

Send this coupon for no-obligation information of the savings under the Medical Society of New Jersey Endorsed Insurance Plans

Check this list against your coverages . . . .

- ☐ $5000 Monthly Guaranteed Convertible Accident and Health
- ☐ $10,000 Monthly Practice Overhead Expense
- ☐ $1,250,000 Term Life Insurance
- ☐ $500 Deductible COMPREHENSIVE MILLION-DOLLAR MAJOR MEDICAL PLAN—No other coverage needed—Issuable to Age 69
- ☐ $15,000 Deductible MILLION-DOLLAR UMBRELLA MAJOR MEDICAL PLAN for holders of Blue Cross and other Major Medical Plans—Issuable to Age 69
- ☐ $100-a-day Hospital Income Policy
- ☐ $200,000 High Limit Accident Plan
- ☐ Keogh and Corporate Plan NOW! $15,000 KEOGH

E. & W. Blanksteen Agency, Inc.

E. & W. Blanksteen
75 Montgomery St.,
Jersey City, N.J. 07302
(201) 333-4340
or (800) 742-2849

Name: _____

Address: _____

_____

Tel. No. _____

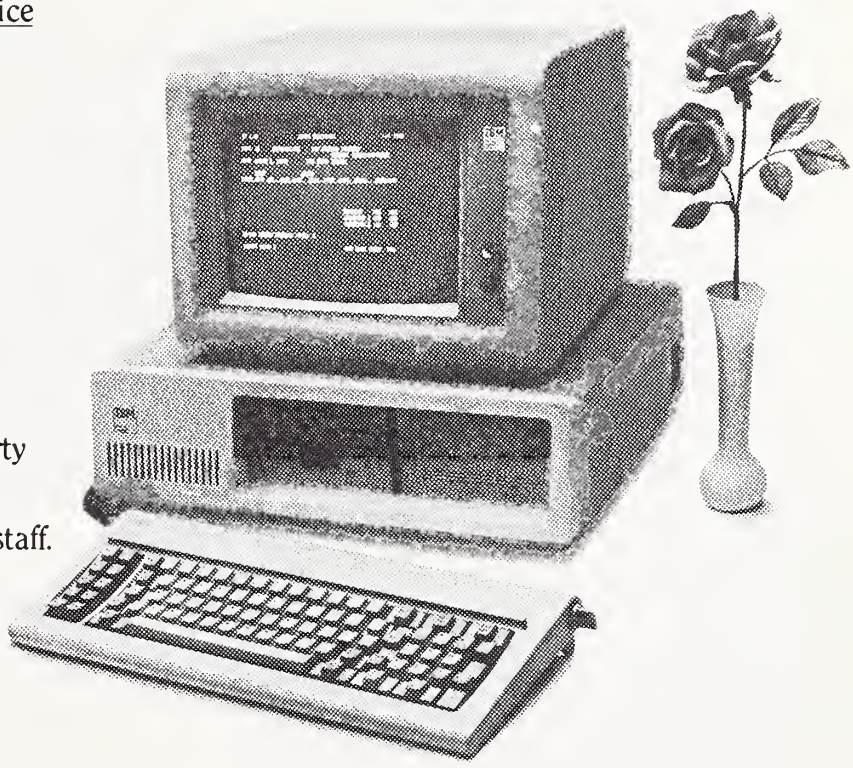
Best Time To Call _____

The IBM Personal Computer
A tool for modern times
In the Medical Office.

MEDI-SCAN®, an Authorized IBM® Value-Added Dealer for the Personal Computer

Our Comprehensive $8,995.00 MEDI-SCAN In-office Billing And Accounting System Includes:

- The IBM Personal Computer XT with 128K, 10 Megabyte hard disk.
- The IBM Graphics Printer.
- MEDI-SCAN software—customized for your practice, including procedure numbers for state agencies. Generates accounting reports, comprehensive patient statements, insurance and third party forms.
- Optional electronic paperless billing to third party agencies, where applicable.
- Training—Complete in-office training for your staff.
- Support—"HOT-LINE" 800 number for continuous support.



MEDI-SCAN Single Source Support System

MEDI-SCAN'S unique, comprehensive hardware and software maintenance agreement guarantees continuing service and repair, system updates and additional customization, plus in-office training—all from one source. Our local training consultants and technicians are dedicated to giving you the best possible service.

IBM Personal Computer XTs are in stock in our local warehouses ready to be immediately installed. Over three hundred physicians are using the MEDI-SCAN System—join them in making the IBM PC-XT "A tool for modern times in the medical office."

Networking available for group practices and clinics

I would like to know more about the MEDI-SCAN System on the IBM Personal Computer XT.

Dr. _____

Address _____

City _____ State _____ Zip _____

Phone (___) _____

Or call: 800-922-1021
In MA: 800-462-1009

Send to: **MEDI-SCAN**
90 Madison Street, Worcester, MA 01608

IBM Authorized Value Added Dealer Personal Computers

MEDI-SCAN

Service centers currently in: *New England* · *Mid Atlantic States* · *Mid Western States* · *California* · *Texas*

® MEDI-SCAN is a registered trademark of PAL Assoc. Inc.
PAL Associates is an Authorized IBM Value-Added Dealer for the Personal Computer.
® IBM is a registered trademark of International Business Machines Corporation.

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

Officers and Trustees

PRESIDENT AND CHAIRMAN OF THE BOARD
Frank Y. Watson, M.D. (Essex) ..... Glen Ridge
PRESIDENT-ELECT
Ralph J. Fioretti, M.D. (Bergen) ..... Rochelle Park
FIRST VICE-PRESIDENT
Edward A. Schauer, M.D. (Monmouth) ..... Farmingdale
SECOND VICE-PRESIDENT
Harry M. Carnes, M.D. (Camden) ..... Audubon
IMMEDIATE PAST-PRESIDENT
Alexander D. Kovacs, M.D. (Union) ..... Scotch Plains
SECRETARY
Arthur Bernstein, M.D. (Essex) ..... South Orange
TREASURER
Paul J. Hirsch, M.D. (Somerset) ..... Bridgewater

Trustees

Joel S. Cherashore, M.D. (1986) (Essex) ..... Nutley
Douglas M. Costabile, M.D. (1987) (Union) ..... Murray Hill
Palma E. Formica, M.D. (1987)
(Middlesex) ..... New Brunswick
Harry W. Fullerton, Jr., M.D. (1985)
(Salem) ..... Carney's Point
Frank Gingerelli, M.D. (1986) (Bergen) ..... Hackensack
Michael M. Heeg, M.D. (1987) (Mercer) ..... Trenton
Louis L. Keeler, M.D. (1985) (Camden) ..... Collingswood
John P. Kengeter, M.D. (1987) (Ocean) ..... Toms River
Edwin W. Messey, M.D. (1985) (Burlington) ..... Willingboro
Myles C. Morrison, Jr., M.D. (1985) (Morris) .... Morristown
John J. Pastore, M.D. (1986) (Cumberland) ..... Vineland
Carl Restivo, Jr., M.D. (1987) (Hudson) ..... Jersey City
Bernard Robins, M.D. (1987) (Essex) ..... Springfield
Gerald H. Rozan, M.D. (1987) (Passaic) ..... Wayne

Councilors

FIRST DISTRICT
(Essex, Morris, Union, and Warren Counties)
Edward M. Coe, M.D. (1987) ..... Cranford
SECOND DISTRICT
(Bergen, Hudson, Passaic, and Sussex Counties)
Robert A. Weinstein, M.D. (1986) ..... Newton
THIRD DISTRICT
(Hunterdon, Mercer, Middlesex, and Somerset Counties)
Louis G. Fares, M.D. (1985) ..... Trenton
FOURTH DISTRICT
(Burlington, Camden, Monmouth, and Ocean Counties)
Frederick W. Durham, M.D. (1987) ..... Haddonfield
FIFTH DISTRICT
(Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties)
Paul H. Steel, M.D. (1986) ..... Atlantic City

AMA Delegates

William J. D'Elia, M.D., *Chairman* (1985) ..... Spring Lake
Alfred A. Alessi, M.D. (1986) ..... Hackensack
Frederick W. Durham, M.D. (1986) ..... Haddonfield
Palma E. Formica, M.D. (1986) ..... New Brunswick
Karl T. Franzoni, M.D. (1986) ..... Trenton
John S. Madara, M.D. (1986) ..... Salem
Henry J. Mineur, M.D. (1986) ..... Cranford
Myles C. Morrison, Jr., M.D. (1985) ..... Morristown
Howard D. Slobodien, M.D. (1985) ..... Metuchen

AMA Trustee

James S. Todd, M.D. (Ridgewood) ..... Bergen

June 1984

Publication Committee

Paul J. Hirsch, M.D., *Chairman*
Dirck L. Brendlinger, M.D.
Frederick B. Cohen, M.D.
A. Olusegun Fayemi, M.D.
Robert M. MacMillan, M.D.
Leon G. Smith, M.D.
La Verne Fioretti

Editor

Arthur Krosnick, M.D.

Managing Editor

Geraldine R. Hutner

Assistant Managing Editor

Dorothy J. Griffith

Advertising Manager

E. Elizabeth Cookson

Executive Director

Vincent A. Maressa

Executive Director Emeritus

Richard I. Nevin

Editorial Board

Jerome Abrams, M.D. (Obstet/Gynecol)
Joseph Alpert, M.D. (Vasc Surg)
Harold Arlen, M.D. (Otolaryngol)
Alfonse Cinotti, M.D. (Ophthalmol)
Robert Dodelson, M.D. (Nephrol)
Norman H. Ertel, M.D. (Int Med/Endocrinol)
Daniel P. Greenfield, M.D. (Psychiat)
Christine E. Haycock, M.D. (Sports Med)
Monroe S. Karetzky, M.D. (Pulmon Med)
Avrum L. Katcher, M.D. (Pediatr)
Stanley C. Leonberg, Jr., M.D. (Neurol)
Joel D. Levinson, M.D. (Gastroenterol)
Henry R. Liss, M.D. (Neurosurg)
Geobel A. Marin, M.D. (Int Med/Gastroenterol)
Donald G. McKaba, M.D. (Allergy)
Robby Meijer, M.D. (Plas Surg)
Frank T. Padberg, Jr., M.D. (Surg)
Christopher A. Papa, M.D. (Dermatol)
Norman Riegel, M.D. (Book Review)
Edwin L. Rothfield, M.D. (Cardiol)
Benjamin F. Rush, Jr., M.D. (Surg)
Morris H. Saffron, M.D. (Med His)
Mark M. Singer, M.D. (Int Med/Endocrinol)
Sheldon D. Solomon, M.D. (Rheum)
Lloyd N. Spindell, M.D. (Radiol)
A. Arthur Sugerman, M.D. (Psychiat)
Stephen F. Wang, M.D. (Pediatr)
Edwin S. Wilson, M.D. (Radiol)
Louis S. Zeiger, M.D. (Nucl Med)
Robert B. Zufall, M.D. (Urol)

The Journal of the Medical Society of New Jersey (ISSN-0025-7524) is published monthly (since 1904) excep semimonthly in July (13 issues), under direction of the Committee on Publication, by the Medical Society of Ne Jersey, Two Princess Road, Lawrenceville, NJ 08648. Printed in East Stroudsburg, PA, by the Hughes Printin Co. Whole number of issues 963. Member's subscription ($10) is included in Society dues. Rates for nonmember $20; outside USA add $7.50 for postage. Single copies, $2. Address communications to *The Journal* MSNJ, Tw Princess Road, Lawrenceville, NJ 08648, (609) 896-1766. Second-class postage paid at Trenton, NJ, and additiona entry office.

Copyright 1984 by the Medical Society of New Jersey.

Motrin®
ibuprofen, Upjohn
600 mg Tablets



More convenient for your patients.

Upjohn

4 The Upjohn Company

The Upjohn Company • Kalamazoo, Michigan 49001 USA

J-4044 January 1984

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

JUNE 198

FEATURES

449 Membership Newsletter
456 Professional Liability Commentary
461 Editorials
465 Hospital Governing Boards
469 Inaugural Address—Frank Y. Watson, M.D.
473 Farewell Address—Alexander D. Kovacs, M.D.
475 MSNJ Auxiliary—Mrs. William B. Gellman
476 Golden Merit Awards

CONTRIBUTIONS

481 Cardiac Amyloidosis and Idiopathic Hypertrophic Subaortic Stenosis
R.A. Daniels, M.D., R. Weinberg, M.D., A.F. Rangwala, M.D., G. Mintz, M.D., Long Branch

487 The Smoking Cessation Reduction Action Program
N. Hymowitz, Ph.D., I. Laquatra, S. Karl, Newark

493 Promoting Compliance in Hypertensive Patients
P. Supino, Ed.D., A.R. Gotsch, Ph.D., D. Van Harlingen, Ed.D., J. Hebble, Piscataway

501 Case Report: Hyperprolactinemia in a Patient with Pseudotumor Cerebri
M. Goldman, M.D., and A. Rabin, M.D., Englewood

503 Pharmacological Basis of Therapeutics: Eicosanoids—Mediators of Biological Functions
D.J. Wolff, Ph.D., Piscataway

507 Impaired Physicians Program: Treatment Loan Fund
D.I. Canavan, M.D., Lawrenceville

DOCTORS' NOTEBOOK

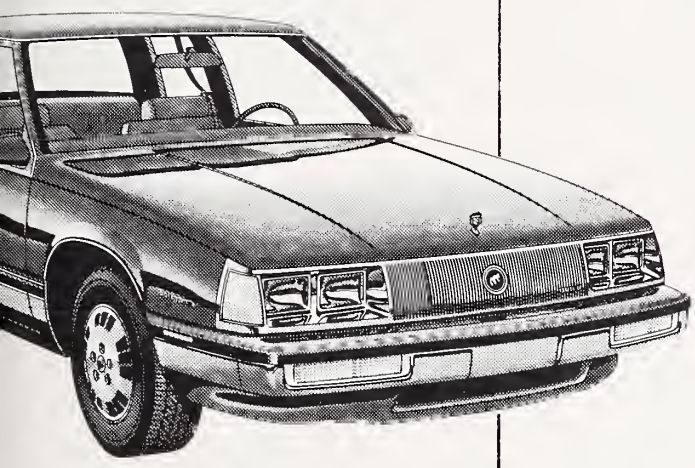
509 Trustees' Minutes: April 15, 1984
510 UMDNJ Notes, Stanley S. Bergen, Jr., M.D.
511 AMNJ Report, Paul J. Hirsch, M.D.
511 New Members
512 Physicians Seeking Location in New Jersey

MSNJ DEPARTMENTS

515 CME Calendar
517 Letters to the Editor
518 Book Reviews
520 Obituaries
522 Information for Authors

On The Cover: Frank Y. Watson, M.D., is the 192nd President of the Medical Society of New Jersey. We congratulate Dr. Watson and wish him every success during his term.





85 BUICK ELECTRA
4-DR SEDAN

ere's a car so new that it's the first of the
5's. But thanks to its front-wheel drive,
ulti-port Fuel Injection, four-wheel
dependent suspension, advanced
erodynamics and generously applied
ectronics, the new Park Avenue will
ay on the leading edge of automotive
esign for many years to come.

PAY NOTHING DOWN & ENJOY 60,000 FREE MILES ON US.

BECAUSE PROFESSIONALS COME FIRST AT FENNESSEY... IT'S THE LEASE WE CAN DO.

Why tie up your precious capital? Drive away today in plush Buick luxury...the modern way, with Fennessey Professional Leasing. Free up your cash. Free yourself from up-front down payments. Budget your car costs conveniently and accurately!

Rt. 202-206 North • Somerville, N.J. 08876
Call 725-3020 •
Open Daily 9-9 • Fri. til 6 • Sat. til 5

SEE

FENNESSEY

FIRST

PHONE US FOR LIMITED MONEY-SAVING PROFESSIONAL LEASING RATE

UY

ntral Jersey's Largest
lection of New Buicks and
ide Cars!

LEASE

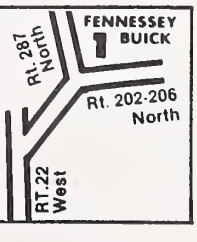
No Down Payment, 60,000 free miles with full mfrs. car warranty.

RENT

Only 29.95 per day for new Buick Skylarks or Skyhawks... always available! 50 free miles.

SO EASY TO REACH!

Only 4 minutes from Somerville



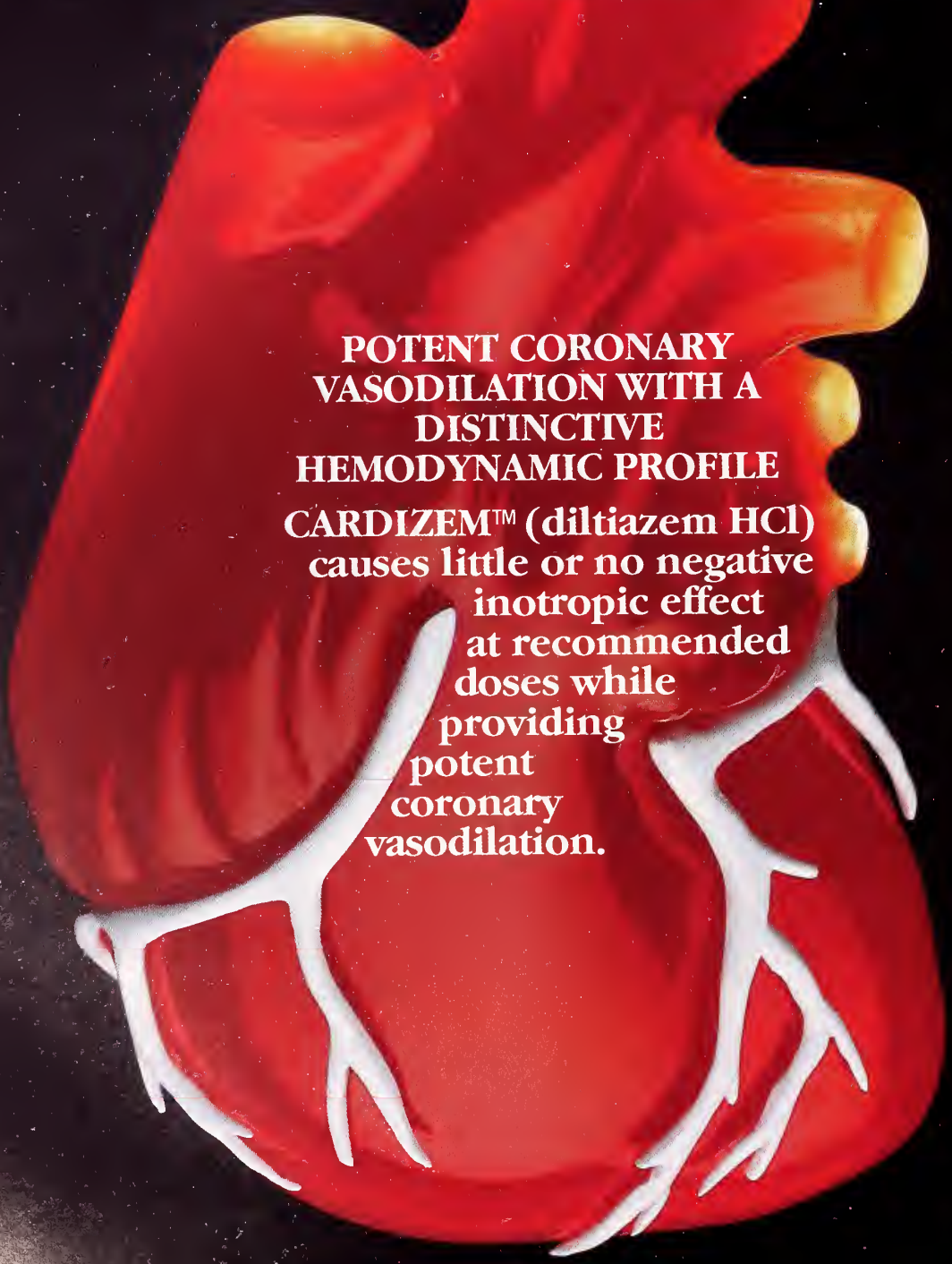
Announcing a major advance
in cardiovascular therapy

CARDIZEM™ (diltiazem HCl)

30 mg and 60 mg tablets

CALCIUM CHANNEL BLOCKADE

from
Marion Laboratories



POTENT CORONARY VASODILATION WITH A DISTINCTIVE HEMODYNAMIC PROFILE

CARDIZEM™ (diltiazem HCl) causes little or no negative inotropic effect at recommended doses while providing potent coronary vasodilation.

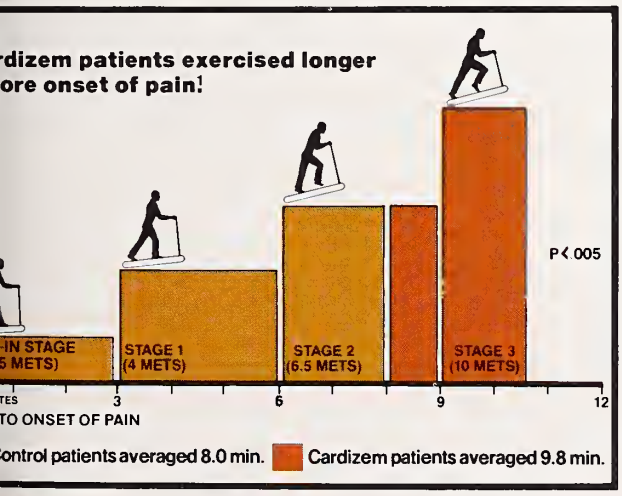
Please see full prescribing information on last page of this

cardizem™
(diltiazem HCl)
30 mg and 60 mg tablets

INCREASES EXERCISE TOLERANCE, REDUCES ANGINAL FREQUENCY* WITH A LOW INCIDENCE OF SIDE EFFECTS

Calcium channel blockade with CARDIZEM™ (diltiazem HCl) produces changes in cardiovascular hemodynamics and coronary blood flow that are of benefit in myocardial ischemia.

CARDIZEM™ (diltiazem HCl) ALLOWS PATIENTS TO SIGNIFICANTLY PROLONG EXERCISE TOLERANCE, EVEN IN DEMANDING BRUCE PROTOCOL EXERCISE TESTS[1] (n = 15)†



This study is of special significance because patients not only exercised longer but *to the next higher stage* in the Bruce protocol.

A Bruce protocol with a run-in stage was used for all tests. Each stage lasts three minutes.

In other studies, Cardizem produced 41% to 68% reduction of Prinzmetal's variant angina attacks[2]

†This study is a report from one center in a multicenter study.

erapy with Cardizem produced a v incidence of side effects.

lacebo-controlled trials (222 patients) ducted in the United States, the incidence dverse reactions reported during Cardizem rapy was not greater than that reported ing placebo therapy.

Those adverse reactions reported most frequently with Cardizem in 959 patients in controlled and uncontrolled U.S. trials have been:

- Nausea 2.7%
- Swelling/edema 2.4%
- Arrhythmia 2.0%
- Headache 2.0%
- Rash 1.8%
- Fatigue 1.1%

Other reactions reported infrequently (less than 1%) are listed in full prescribing information on adjacent page.

Please see adjacent page for full prescribing information.

rences:

ol PE, Seagren SC, Bonanno JA, et al: The treatment of ercise-inducible chronic stable angina with diltiazem: Effect treadmill exercise. *Chest* 78 (July suppl): 234-238, 1980.

hroeder JS, Feldman RL, Giles TD, et al: Multiclinic ntrolled trial of diltiazem for Prinzmetal's angina. *Am J Med* :227-232, 1982.

83, Marion Laboratories, Inc.

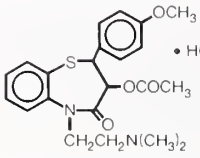
PROFESSIONAL USE INFORMATION

cardizem™ (diltiazem HCl)

30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM™ (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy)-5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+)-cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate/blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent as a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents. CARDIZEM has been effective in short-term controlled trials in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness is incomplete.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (four of 959 patients for 0.42%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** There has been a single report in a patient receiving 120 mg of diltiazem tid of marked transaminase elevation (SGOT 4500, SGPT 2300) accompanied by hyperbilirubinemia (to 3 mg%), occurring after four days of treatment. The enzyme abnormalities resolved entirely, and enzymes were nearly normal a week after cessation of treatment. No rechallenge was carried out, but the patient had no evidence of viral hepatitis and received no other drugs but isosorbide dinitrate.

   No other similar liver injury has been reported in clinical trials, but marketing experience in Europe has resulted in a rechallenge-confirmed instance of hepatocellular injury. However, it should be noted that there have been further episodes of raised transaminases in the absence of diltiazem in this patient, so that the relationship to diltiazem of the abnormalities is not completely clear. Other instances of transaminase elevation have been reported in Europe, but their relationship to the drug is uncertain.

PRECAUTIONS

General. CARDIZEM is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities; the effect of diltiazem on serum digoxin levels has not been examined. The safety of the combination of CARDIZEM and beta-blockers or digitalis is currently being investigated in well-controlled studies.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried ou to date, but it should be recognized that patients with impaire ventricular function and cardiac conduction abnormalities hav usually been excluded. Experience with an added beta-blocker i also extremely limited.

In domestic placebo-controlled trials, the incidence of advers reactions reported during CARDIZEM therapy was not greater tha that reported during placebo therapy.

In addition, the following have been reported infrequently an represent occurrences which can be at least reasonably associate with the pharmacology of calcium influx inhibition. In many case the relationship to CARDIZEM has not been established. The mo common occurrences, as well as their frequency of presentatio are nausea (2.7%), swelling/edema (2.4%), arrhythmia (2.0% headache (2.0%), rash (1.8%), and fatigue (1.1%). In addition, th following events were reported infrequently (<1.0%). The order presentation corresponds to the relative frequency of occurrence

Cardiovascular:	Flushing, congestive heart failure, bradycardi hypotension, syncope, pounding heart.
Central Nervous System:	Drowsiness, dizziness, lightheadedness, nervou ness, depression, weakness, insomnia, confusio hallucinations.
Gastrointestinal:	Vomiting, diarrhea, gastric upset, constipatio indigestion, pyrosis.
Dermatologic:	Pruritus, petechiae, urticaria.
Other:	Photosensitivity, nocturia, thirst, paresthesia polyuria, osteoarticular pain.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes vasospastic angina developed periods of transient asymptomat asystole approximately five hours after receiving a single 60-m dose of CARDIZEM.

Experience in 959 patients taking oral doses of CARDIZE resulted in three cases (0.31%) of second-degree AV block a one case (0.10%) of third-degree AV block at doses of 240 360 mg daily.

In rare instances, mild to moderate transient elevations of alkali phosphatase, SGOT, SGPT, LDH, and CPK have been noted duri CARDIZEM therapy. A single incident of markedly elevated li enzymes associated with symptoms was reported in a patient taki 360 mg per day for four days. Drug was discontinued and enzym normalized within 1 week.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experiences with oral diltiazem have not been report Single oral doses of 300 mg of CARDIZEM have been well tolerat by healthy volunteers. In the event of overdosage or exaggerat response, appropriate supportive measures should be employ in addition to gastric lavage. The following measures may considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is response to vagal blockade, administer isop terenol cautiously.
High-degree AV Block	Treat as for bradycardia above. Fixed high-deg AV block should be treated with cardiac pacin
Cardiac Failure	Administer inotropic agents (isoproterenol, do mine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levartere bitartrate).

Actual treatment and dosage should depend on the severity the clinical situation and the judgment and experience of the treat physician.

The oral LD_{50}'s in mice and rats range from 415 to 740 mg, and from 560 to 810 mg/kg, respectively. The intravenous LD in these species were 60 and 38 mg/kg, respectively. The LD_{50} in dogs is considered to be in excess of 50 mg/kg, w lethality was seen in monkeys at 360 mg/kg. The toxic dose in r is not known, but blood levels in excess of 800 ng/ml have been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coron Artery Disease or Angina Pectoris at Rest Due to Coron Artery Spasm. Dosage must be adjusted to each patient's nee Starting with 30 mg four times daily, before meals and at bedti dosage should be increased gradually to 240 mg (given in divi doses three or four times daily) at one- to two-day intervals u optimum response is obtained. The effectiveness and safet dosages exceeding 240 mg per day are currently being investiga There are no available data concerning dosage requirement patients with impaired renal or hepatic function. If the drug n be used in such patients, titration should be carried out particular caution.

Concomitant Use With Other Antianginal Agents.

1. **Sublingual NTG** may be taken as required to abort a anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be s coadministered with short- and long-acting nitrates, but t have been no controlled studies to evaluate the antian effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

CARDIZEM 30-mg tablets are supplied in bottles of 100 (0088-1771-47). Each green tablet is engraved with MARION on side and 1771 engraved on the other. CARDIZEM 60-mg sc tablets are supplied in bottles of 100 (NDC 0088-1772-47). yellow tablet is engraved with MARION on one side and 177 the other.

Issued 1

Another patient benefit product from

PHARMACEUTICAL DIVISION
MARION LABORATORIES, INC.
KANSAS CITY, MISSOURI 64137

MEMBERSHIP NEWSLETTER

MSNJ

THE MEDICAL SOCIETY OF NEW JERSEY VOLUME 12

BLUE SHIELD VIOLATES ANTITRUST LAW

A federal district court in Massachusetts has ruled that Blue Shield's ban on balance billing by participating physicians imposes an unreasonable restraint on competition.

In Massachusetts, Blue Shield provides coverage only when services are rendered by a participating physician. Since Blue Shield holds the dominant market share, physician participation becomes a matter of economic necessity rather than voluntary. All physicians are reimbursed at the same maximum price level regardless of skill or training.

The court found that the restraint adversely impacts on the patient's choice of physician and affects competition among physicians.

MANDATED ASSIGNMENT DEFEATED IN HOUSE

On April 12, 1984, the U.S. House of Representatives considered a proposal to freeze Medicare reimbursement for physician services for a year—coupled with mandated acceptance of Medicare assignment for services to hospitalized patients. The House rejected the proposal in a voice vote. It is likely the issue will be considered again in the fall.

ADVERTISING AND SOLICITATION PRACTICES

On March 14, 1984, pursuant to the authority of N.J.S.A. 45:9-2, the Board of Medical Examiners repealed the former text of N.J.A.C. 13:35-6.10 regulating advertising and solicitation practices of licensees of the Board of Medical Examiners, and in accordance with the applicable provisions of the Administrative Procedure Act, the Board adopted in its place under the same citation the text proposed and published at 16 N.J.R. 32 on January 3, 1984, with changes not in violation of N.J.A.C. 1:30-3.5. Further, the Board voted to alert readers in the published notice of adoption that a new provision restrictive of certain styles of advertising in public media will be proposed in the next available *Register* (that is, a provision prohibiting drawings, animations, clinical photographs, dramatizations, music or lyrics in radio or television advertisements) which will be added to the present adopted text as new section (m).

The other changes, deemed not to require republication, are the following: grammatical correction to N.J.A.C. 13:35-6.10 (d) and (1) to make clear that the paragraph pertained to the Board of Medical Examiners, and a spelling correction in f(2). N.J.A.C. 13:35-6.10(e) is modified in response to public comments to make clear that traditional community-based informational services such as Welcome Wagon may continue to include announcements and information or literature from licensees. Also, new wording was adopted for N.J.A.C. 13:35-6.10(h) based upon the suggestion of New Jersey Bell Telephone which advised that the proposed wording would result in considerable expense to Board licensees in advertising media such as telephone yellow pages; the Board determined that, while all licensees must be identified on professional stationery and at the office location, advertisements intended for off-premises display or circulation need list only the professional service corporation or trade name along with nature of practice, address or telephone number, and the name of at least one of the practicing licensees. The Board's responses to other public comments is set forth in a committee report which was reviewed and adopted by the Board on March 14. The report is available for public inspection. The Board's determination to continue to prohibit the advertising of "free services" or the substantial equivalent of free services (for example, "$5 examination") was, as noted in the report, supported by testimony presented at the public hearing conducted on October 6, 1983. Not only did respected and credible witnesses speak on the high abuse potential of "free service" advertising done within the confines of a physician's office, but those speaking in favor of it described the very effects that the Board had feared as in fact happening in office settings where certain practitioners were inducing the public to come in with an offer of "free examination."

Full text of the adoption follows (additions to the proposal shown in boldface with asterisks *thus*; deletions from the proposal shown in brackets with asterisks *[thus]*).

13:35-6.10 Advertising and solicitation practices

(a) Definitions: The following words and terms when used in this section shall have the following meanings unless the context clearly indicates otherwise.

1. The term "advertisement" shall mean any attempt directly or indirectly by publication, dissemination, or circulation in print or electronic media which directly or indirectly induces or attempts to induce any person or entity to purchase or enter into an agreement to purchaser services, treatment, or goods related thereto from a Board licensee.

2. "Board licensee" shall mean any individual holding a license issued by the State Board of Medical Examiners.

3. The term "routine professional service" shall refer to a service which a board licensee or professional association routinely performs.

4. The term "print media" shall include newspapers, magazines, periodicals, professional journals, telephone directories, circulars, handbills, flyers, billboards, signs, matchcovers and other similar items, documents or comparable publications, the content of which is disseminated by means of the printed word. The term shall not include aerial displays.

5. The term "electronic media" shall include radio and television, but shall not include communications made by sound equipment from a motor vehicle.

6. The term "range of fees" shall refer to an expressly stated upper and lower limit on the fees charged for services or goods offered by a Board licensee.

(b) A Board licensee may provide information to the public by advertising in print or electronic media.

(c) A Board licensee who engages in the use of advertising which contains any of the following shall be deemed to be engaged in professional misconduct:

1. Any statement, claim, or format which is false, fraudulent, misleading or deceptive;

2. Any misrepresentation of a material fact;

3. The suppression, omission, or concealment of any material fact under circumstances which a Board licensee knows or should know that the omission is improper or prohibits a prospective patient from making a full and informed judgment on the basis of the information set forth in the advertisement;

4. Any claim that the service performed or the materials used are superior to that which is ordinarily performed or used in the profession;

5. Any promotion of a professional service which the Board licensee knows or should know is beyond the licensee's ability to perform;

6. A technique or communication which appears to intimidate, exert undue pressure, or to unduly influence a prospective patient or consumer;

7. Any personal testimonial attesting to the quality or competence of a service or treatment offered by a licensee;

8. The communication of any fact, data, or information which may personally identify a patient;

9. An offer to pay, give, or accept a fee or other consideration to or from a third party for the referral of a patient;

10. Any print, language, or format which directly or indirectly obscures a material fact;

11. Any statement offering gratuitious services or the substantial equivalent thereof, provided, however, nothing herein contained shall be deemed to prohibit the rendering by a Board licensee of professional services for which no fee is charged.

(d) *[A] The* licensing board may require a licensee to substantiate the truthfulness of any assertion or representation set forth in an advertisement. Failure of a Board licensee to provide factual substantiation to support a representation or assertion shall be deemed professional misconduct.

(e) A Board licensee shall not engage either directly or through the use of any agent, employee, or representative in in-person solicitation with a prospective patient or consumer. This subsection shall not prohibit *licensee from offering services through materials provided to a community service organization which makes known the availability of all professional services desiring to be listed; nor shall it prohibit* the offering of services by a Board licensee to any bona fide representative of prospective patients including but not limited to employers, labor union representatives, or insurance carriers.

(f) Advertising making reference to or setting forth a fe shall be limited to that which contains a fixed or a state range of fees for specifically described routine professiona services or goods offered by licensees.

1. A Board licensee who advertises fees shall disclose a relevant and material variables and considerations which ar ordinarily included in such a service so that the fee will b clearly understood by prospective patients or consumers.

2. In the absence of such disclosure referred to in (f) above, the stated fees shall be presumed to include everythin ordinarily required for such a service. No additional charge shall be made for an advertised service unless th advertisement includes a specific delineation of additiona services contemplated in the fee to be charged therefore.

(g) Offers of discounts or fee reductions shall state a bon fide fee or range of fees against which such discounts are t be made.

(h) *[All Board licensee advertisements and publi representations shall contain the name and address c telephone number of the Board licensee, professional servic corporation, or trade name under which the practice conducted and shall also set forth the names of all licensee who are principals, partners, or officers in the firm or enti identified in the advertisement and the nature of th professional practice.] The name and nature of profession practice of every licensee practicing independently or as a employee of another licensee or of a professional servic corporation shall appear on professional stationery and sha be conspicuously displayed and kept at the entrance of th place where the licensed practice is conducted*

(i) The responsibility for the form and content of ar advertisement offering services or goods by a Board licens shall be jointly and severally that of each Board licensee wh is a principal, partner, or officer of the firm or entity identifie in the advertisement.

(j) The time period during which an advertised fee w remain in effect shall be set forth on the face of th advertisement. In the absence of such disclosure, the effecti period shall be deemed to be 30 days from the date of th advertisement's *[initial] final* publication.

(k) A video or audio tape of every advertisemer communicated by electronic media shall be retained by th Board licensee and shall be made available for review upo request by the Board or its designee. A copy of ar advertisement appearing in the print media shall also b retained by the licensee and made available for review. Th tapes and print media copies required to be retained by th subsection, shall be kept for a period of three years from th date of the last authorized publication or dissemination the advertisement.

(l) All Board licensee advertisements and publ representations intended to be displayed or circulated aw from the office premises shall contain the name and addre or name and telephone number of the Board licensee or t professional service corporation or trade name under whi the practice is conducted and the nature of the professior practice. All such advertisements, including telepho directory advertisements may, if desired, list only t professional service corporation or trade name but mu disclose the nature of the practice, and address or telepho number, and the name of at least one of the princi practitioners.

(m) (Reserved)

[l](n) Nothing contained in this section shall construed to prohibit *[a] the* licensing board from adopti additional regulations concerning advertising by Boa licensees. To the extent that any conflict or inconsistency m arise between the provisions of this section and a subsequently adopted rule dealing more specifically with t same subject matter as set forth, such subsequent adop rule shall control.

TWIN CLUB

One of the goals of the New Jersey Association Twins' Mothers Clubs is to assist researchers in a

ay possible to learn more about development of twins. he association maintains a Permanent Twin Registry ith approximately 700 names on file. The National rganization of Mothers of Twins Clubs, Inc. has a ermanent listing of adult twins. If you are interested doing twin research or if you know of anyone with at interest, please do not hesitate to contact the club.

ATIONAL ORGAN TRANSPLANTATION CT—MEDICARE AMENDMENTS

The AMA and 24 medical specialty and hospital ganizations, in a joint statement, called for the letion of major Medicare amendments from H.R. 080, the National Organ Transplantation Act. The edicare amendments would allow the Secretary of HS to ration any health care technology or procedure / establishing reimbursement criteria for Medicare neficiaries, physicians, medical facilities, and the nditions under which the technology or procedure uld be provided. These Medicare amendments are t limited to transplantation and never received tention as to their impact during Subcommittee arings.

E CAREFUL

The State Board of Medical Examiners voted to affirm the policy regarding the use of rubber gnature stamps by doctors with the following arification: "Any professional interpretation by a ysician, whether that physician be a pathologist or diologist, requires the full original signature of the ysician rendering that professional interpretation. ports of test results which have not required an dividual professional interpretation, such as but not nited to CBC, need not be individually signed."

JBLIC OPINION/DOCTOR RELATIONS

Depending on to whom you listen the image of the edical profession rides a roller coaster. Some surveys e reported to indicate individual physicians still are ld in high regard by their patients. The same surveys so point out that the opinion of the overall profession ow signs of erosion.

Many of the complaints relate to what appears to be k of consideration and dehumanized relationships tween the patients and the providers of medical care. The profession is beleaguered by various political d economic forces according to John Corboy, M.D., *Hawaii Medical Journal*. He suggests that ysicians take a tip from their unschooled mpetitors and get back to basics. Try to utilize the erwhelming therapeutic power of true concern, uch, support, and personal reassurance. Take an tra minute for the magic; it's very good medicine. We have a collection of various media articles on the ctor-patient relationship that are enlightening. You n request copies by writing to MSNJ, c/o Public lations, Two Princess Road, Lawrenceville, NJ 648.

W COMPREHENSIVE MAJOR MEDICAL PLAN S LOWER COSTS FOR YOUNGER MEMBERS

Your Society now endorses a true, comprehensive jor Medical Plan, administered by E. & W. Blanksteen, which provides complete medical care protection in one package. Because of its $500 deductible and age-rated premiums, a full family under 40 can be fully covered for hospital and medical expenses for under $1,000 a year. No Blue Cross or other hospital coverage is needed when you have this policy.

Here is a description of the Plan for members and dependents who have not yet reached the age of eligibility for Medicare:

After a $500 deductible, the Plan covers:

a) full semiprivate room cost (including full intensive/coronary care);

b) all other hospital charges (except phone or TV);

c) 80 percent of all physicians' and surgeons' fees;

d) $64 each eight-hour shift for special nurses; and

e) 80 percent of prescriptions drugs, laboratory and x-ray charges, physiotherapy, and local ambulance charges.

You can choose this plan as your only hospital/medical/surgical/nursing protection, if only you are willing to assume the following obligations yourself:

1) the $500 deductible for each illness;

2) the difference between the full charge for special nurses and the policy's $64 per eight-hour shift;

3) 20 percent of physicians' and surgeons' fees; and

4) out-of-hospital mental disorders, which are not covered.

For this comprehensive protection, your total annual cost for family coverage, with children to age 25, is only:

If you are	Your family cost is
Under 40	$932
40-49	1,384
50-59	1,988
60-64	2,806

Special Medicare Supplement is provided for Medicare-age participants.

The new plan will enable a prudent member to control his health insurance cost commitment and at the same time control his own exposure to much of the expense-risk of sickness or injury in the family.

E. & W. Blanksteen always is ready to help you to answer any questions you may have. For information (or a personal appointment, if you wish), call 201-333-4340 or, toll-free, 800-742-2849.

SOME INSURANCE PREMIUMS GO DOWN

The Society's endorsed Professional Overhead Expense Plan with E. & W. Blanksteen, through the Nationwide, has just had its second rate decrease in five years.

Overhead Expense policies help pay those expenses pertaining to your practice when you are unable to practice because of sickness or injury. These expenses include the cost of malpractice insurance. Employees' salaries, rent, or mortgage interest constitute the major Overhead Expenses in the conduct of a medical and surgical practice.

Without Overhead coverage, a physician must spend savings or disability income insurance benefit

payments to keep a temporarily unproductive practice going. At today's cost levels, this can be next to impossible.

If a disability should last longer than a month or two, a physician who has too little Overhead insurance coverage can find that he is forced to a premature decision as to whether to keep his office and staff functioning or to close the office, or at least reduce his staff.

Most of these problems can be avoided simply by bringing one's practice overhead benefits up to today's necessary levels. The time is propitious, since premiums have been reduced for all participants from 9 percent to as much as 30 percent under this endorsed Plan with Blanksteen and the Nationwide.

To calculate how much Overhead Expense insurance you need, the technique is simple: A physician divides the major expenses of his practice into monthl portions—insurance premiums, employee salarie rent or mortgage interest payments, taxes, utilitie accounting and legal retainers, telephone, an answering services. The sum of these represents th cost of maintaining the practice during a disability

The recent premium reduction, plus the fact th premiums are tax-deductible, makes the Society's Pla an exceptional bargain for all members.

Full information, as well as an application an descriptive information and counseling are availab from E. & W. Blanksteen who may be reached b calling, toll-free, 800-742-2849, or at 201-433-4340.

FINI

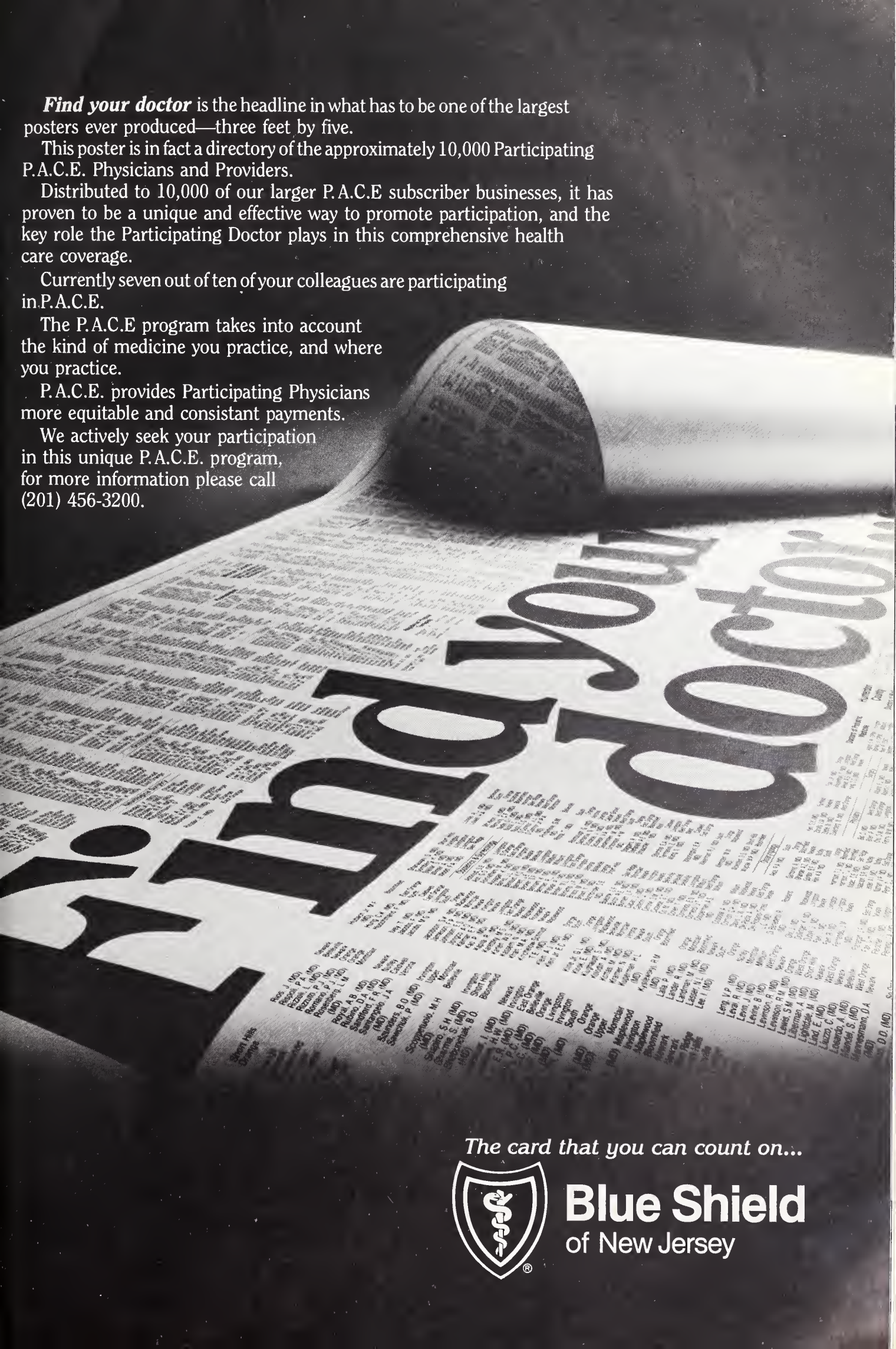
Why can't life's big problems come when we are 2 and know everything?

AN ACT OF LOVE

Their own **DENIAL** that a respected colleague could be **IMPAIRED** and/or the "conspiracy of silence" that makes them unwilling to speak out allows the illness of our impaired colleagues to progress, sometimes to a fatal outcome.

"Blowing the whistle" on a suffering colleague is indeed an **ACT OF LOVE!**

Call Us **EARLY**
We can help **CONFIDENTIALLY**
IMPAIRED PHYSICIANS PROGRAM
(609) 896-1766
Hot Line . . . (609) 896-1884



Find your doctor is the headline in what has to be one of the largest posters ever produced—three feet by five.

This poster is in fact a directory of the approximately 10,000 Participating P.A.C.E. Physicians and Providers.

Distributed to 10,000 of our larger P.A.C.E subscriber businesses, it has proven to be a unique and effective way to promote participation, and the key role the Participating Doctor plays in this comprehensive health care coverage.

Currently seven out of ten of your colleagues are participating in P.A.C.E.

The P.A.C.E program takes into account the kind of medicine you practice, and where you practice.

P.A.C.E. provides Participating Physicians more equitable and consistant payments.

We actively seek your participation in this unique P.A.C.E. program, for more information please call (201) 456-3200.

The card that you can count on...

Blue Shield
of New Jersey

WHY AMA?

Through the AMA library you can have immediate access to a vast store of medical, scientific, and socio-economic information. The library maintains a large collection of books, journals, and microfilm and provides instant on-line access to countless information sources through computerized data bases. The AMA library: it's one more good reason why you should be a part of the AMA.

To Join,
Contact your county or state medical society or write: Division of Membership, AMA, 535 North Dearborn Street, Chicago, Illinois 60610 or call collect, (312) 751-6196.

AMA
AMERICAN MEDICAL ASSOCIATION

References:
1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PRDCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PRDCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure affer beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PRDCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PRDCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PRDCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PRDCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGDT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PRDCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PRDCARDIA CAPSULE contains 10 mg of nitedipine. PRDCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request. © 1982, Pfizer Inc.

Pfizer LABORATORIES DIVISION
PFIZER INC.

"I can do things that I couldn't do for 3 yrs. including joining the human race again."



Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

© 1983, Pfizer Inc.

"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

Please see PROCARDIA *brief summary on adjoining page.*

PROFESSIONAL LIABILITY COMMENTARY*

Case Reports

Obstetrics Malpractice Action; Intestinal Ailment Award; Breast Cancer Case

An obstetrics malpractice action brought on behalf of the 21-year-old daughter of a New Jersey plaintiff contended that as a result of the negligence of the defendant ob/gyn, who administered the labor-inducing drug Tocosamine® (despite the fact that it was contraindicated in that the mother was not experiencing a difficulty with labor), the daughter sustained cerebral palsy at birth and permanently will be unable to walk, use her arms, or talk.

The plaintiff's contentions originally had been on her own recollection of the events which transpired and, in addition to the alleged improper administration of the Tocosamine®, included allegations that the defendant deviated in failing to perform a cesarean section, and that the anesthesiologist deviated in administering a "high" spinal anesthetic instead of a saddle anesthetic, resulting in a dangerous drop in blood pressure. The infant's records which subsequently were located, established that the Tocosamine®, in actuality, was administered. The defendant's own records indicated that there was an uneventful labor and that the only difficulty was the tight cor wrapped around the neck of the infant at birth. Th plaintiff deemed its documentary evidence was quit strong in that it established that the drug was admin istered when the mother was not failing to contract The plaintiff determined that this probably induce abnormally long contractions which caused th cerebral palsy. Additionally, a significant aspect of th case contributing to both the finding of liability an the size of the award, was the inconsistent position c the defendant ob/gyn, who initially denied havin prescribed the Tocosamine® and then maintained tha there must have been a justification for giving it afte the records were found. This inconsistency wa thought to be especially damaging to the defendant' case in light of the horrendous nature of the injurie sustained by the child. The evidence of the extensiv cost of permanent institutionalization, which at pres ent amounts to $30,000 per year, also was significan in the size of this award. The award was more tha $2 million greater than the insurance coverage and th plaintiff had made a timely demand of the carrier t pay the amount equal to the limits of coverage. Thi demand was refused until the trial already had com menced when the defendant offered a settlement of minimum of $100,000 if the defendant prevailed an the policy limits if the plaintiff prevailed and the awar was greater than these limits. The plaintiff declined t accept this offer. The plaintiff's position is that thi offer clearly established the physician's willingness t settle and that the bad faith refusal lay with the carrie and not with the physician. (*New Jersey Verdict Re view and Analysis*, 1984)

$2 MILLION AWARD GRANTED

A 21-year-old New Jersey woman has accepted medical malpractice award of more than $2 millio from a jury that found her physician did not diagnos an intestinal ailment in time to prevent major surger The jury found that the defendant physician did n diagnose the condition of ulcerative colitis in sufficie time to prevent the need for an operation in which th plaintiff's entire colon and rectum had to be remove

At age 16 the plaintiff first complained to her ph sician of rectal bleeding in March 1979.

According to the plaintiff's court depositions, sh was given medication and told to return in two week if the symptoms did not subside. In a deposition, sh said her condition seemed better so she did not retur for a followup visit until 11 months later, when th bleeding recurred. The plaintiff's condition worsen until she had to be hospitalized over New Year's wee end of 1981 with a severe infection of the colon. Whe her condition did not improve, surgery was perform three weeks later.

Plaintiff's attorneys contended during the trial th the physician's failure to diagnose the ulcerative colit led to the severe colon infection which led to the su gery. He said that the surgery is irreversible and th best medical science can offer his client is an operati

*This item from the Department of Professional Liability Co trol, MSNJ, was prepared by James E. George, M.D., J.D., a A. Ronald Rouse who are, respectively, Director of the Depa ment and Director of Special Projects.

to place a pouch used for excreted wastes inside rather than outside the body.

Court records indicate that the plaintiff had offered to settle the case for $1 million, the full amount of the physician's insurance coverage, prior to trial. (*Asbury Park Press*, February 4, 1984)

VERDICT FOR FAILURE TO DIAGNOSE BREAST CANCER

A medical malpractice action brought by a 65-year-old woman contended that as a result of the negligent failure of the defendant pathologist to diagnose breast cancer, the condition was not detected until some 13 months later, resulting in a significantly diminished probability of survival, the performance of a total Halstead mastectomy (rather than less radical surgery), and the requirement for 3 years of chemotherapy (rather than the typical course of such treatment which would continue for 6 months only). The defendant did not dispute that a misdiagnosis had occurred. The plaintiff had a 20-year history of fibrocystic disease which entailed the relatively frequent presence of benign growths on the left breast. Following the removal of a lesion, six slides were prepared by the defendant who diagnosed a benign condition. Thirteen months later, a lesion was detected below the left breast and testing confirmed that the plaintiff had a rather advanced case of breast cancer. The plaintiff's expert oncologist maintained that based upon a review of the slides utilized by the defendant in his diagnosis of a benign growth, it was evident that the defendant had deviated. The expert related that the slides depicted cancer-type cells which were lined up in "Indian file," clearly evidencing a malignancy. The expert maintained that based upon the slides, no other valid diagnosis could possibly be made.

The plaintiff's treating immuno-oncologist from Sloan-Kettering Memorial Hospital, New York City, maintained that during the 13-month period which elapsed until the condition was diagnosed correctly, it deteriorated from a malignancy which probably could have been treated with a modified radical mastectomy to a condition which required the removal of a large portion of the chest wall and a great many lymph nodes in the arm. The physician maintained that had the malignancy been diagnosed by the defendant in a timely manner, only six months of chemotherapy would have been required and that the plaintiff's chances of recovery would have been quite good. He maintained that as a result of the deviation, the plaintiff is in a program requiring three years of chemotherapy which still is continuing. The physician maintained that because of the delay in diagnosis, the chances of a recurrence are approximately 70 percent and contended that in the event of such a recurrence, the plaintiff probably will die. The defendant's expert oncologist conceded that a recurrence probably would be untreatable, but maintained that the chances of such a recurrence are only 40 to 50 percent.

The plaintiff contended that she has suffered a psychological injury which largely stemmed from the fact that the malignancy probably could have been treated successfully. Her treating therapist, a psychiatric social worker from New York City, related that the plaintiff withdrew from a therapy group comprised of breast cancer patients because the contrast between the relatively favorable prognoses in the other women in the group, whose cancer had been detected in a timely manner, and her own prognosis, filled her with great consternation. The social worker maintained that the psychological condition probably never will improve. (*New Jersey Jury Verdict Review and Analysis*, Vol. IV, No. 16, Jan. 23, 1984)

DID YOU KNOW . . .

Eighteen of those physicians dropped from MSNJ for failure to complete the CME credits account for 32 malpractice claims? A breakdown showed: 11 physicians with 1 claim; 1 with 3 claims; 3 with 4 claims each; 1 with 5 claims; 1 with 7 claims; and 1 with 8.

When three pediatricians in New York sued to collect $61 in unpaid medical bills, they triggered a $5 million malpractice suit? The parents of a former patient allege that the doctors mistreated their daughter's ear problem, which began when she was six months old. Although the physicians treated the child for nearly three years, the parents say there was no improvement in her hearing or in the speech impediment resulting from the ear problem. The parents claim that when they requested another opinion, the doctors angrily terminated the relationship—and the couple left without paying their bill. The pediatricians have since dropped the collection suit, but the malpractice suit still is pending.

By age 45, the pattern of malpractice susceptibility for ob/gyns—one of the most vulnerable of the specialties—is fairly well-established? Some 25 percent, age 45 and older, never have been sued; about 30 percent have been sued once; and nearly 18 percent have been sued twice. (*Medical Economics*, February 6, 1984)

In January, the New York State Society of Internal Medicine, in conjunction with a commercial insurance carrier, began offering some members a plan that will reduce malpractice premiums by 17 to 20 percent? But eligibility is controlled tightly; the Society must certify that the doctors do not subspecialize. Internists who paid $4,600 to $10,200 for $1 million/$3 million coverage in 1983 now can have the same coverage for $3,800 to $8,400. And those who take a 12-hour course on the risk management sponsored by the Society get another 10 percent off. (*Medical Economics*, February 6, 1984)

Out-of-hospital child birth centers, which generally are staffed by nurse-midwives, are increasing in number? According to Cooperative Birth Center Network of Perkiomenville, Pennsylvania, there currently are 105 such centers in 31 states, 25 percent of which are less than a year old, with prospects for 300 more in the near future.

Northbrook Indemnity Company of Illinois, a wholly-owned affiliate of Allstate Insurance, will be underwriting professional liability coverage for medical groups exclusively through Charles Stedman Group of Sarasota, Florida? According to Stedman, "Medical clinics are much preferred underwriting risks." (*Medical Liability Monitor*, December 24, 1983)



Angina Protection with Benefits for a Lifetime

ONCE-DAILY CONTROL WITH HEART-SAVING BENEFITS

By reducing heart rate and cardiac contractility, INDERAL LA helps protect the heart from the potentially serious and debilitating consequences of ischemia. A highly effective antianginal agent for around-the-clock control of symptoms, INDERAL LA also provides cardiovascular protection for a sense of security in the years ahead.

PROTECTION AND EXPERIENCE NO CALCIUM BLOCKER CAN MATCH

Unlike calcium blockers, INDERAL LA—either alone or with a nitrate—is recommended for early treatment of angina in the majority of patients. Equally important, INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use.

START WITH 80 MG ONCE DAILY

Dosage may be increased to 160 mg once daily, as needed, to achieve optimal control. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY **INDERAL LA** (PROPRANOLOL HCl) *LONG ACTING CAPSULES*



Ayerst®

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

JUST ONCE EACH DAY FOR SIMPLIFIED CORE THERAPY IN ANGINA

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)*

INDERAL™ LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, ano syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking ther prior to major surgery is controversial. It should be noted, however, that the impaired abili the heart to respond to reflex adrenergic stimuli may augment the risks of general anesth and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of b receptor agonists and its effects can be reversed by administration of such agents, dobutamine or isoproterenol. However, such patients may be subject to protracted se hypotension. Difficulty in starting and maintaining the heartbeat has also been reported beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the pearance of certain premonitory signs and symptoms (pulse rate and pressure change acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be r difficult to adjust the dosage of insulin

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroid Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of sympt of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function te

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have b reported in which, after propranolol, the tachycardia was replaced by a severe bradyca requiring a demand pacemaker. In one case this resulted after an initial dose of 5 propranolol.

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impa hepatic or renal function. INDERAL is not indicated for the treatment of hyperten emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Pati should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart dise elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as re pine should be closely observed if INDERAL is administered. The added catecholam blocking action may produce an excessive reduction of resting sympathetic nervous act which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthos hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals h been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studie both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of signifi drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dos levels. Reproductive studies in animals did not show any impairment of fertility that attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxi animal studies at doses about 10 times greater than the maximum recommended human d

There are no adequate and well-controlled studies in pregnant women. INDERAL sh be used during pregnancy only if the potential benefit justifies the potential risk to the fe

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised w INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and h rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block; h tension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually o Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insom lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; vi disturbances; hallucinations; an acute reversible syndrome characterized by disorientatio time and place, short-term memory loss, emotional lability, slightly clouded sensorium, decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarr constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with ac and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytop purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has b reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male in tence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reac involving the skin, serous membranes and conjunctivae reported for a beta blocker (pract have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride sustained-release capsule for administration once daily. If patients are switched from INDE tablets to INDERAL LA capsules, care should be taken to assure that the desired therap effect is maintained. INDERAL LA should not be considered a simple mg for mg substitut INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration be necessary especially to maintain effectiveness at the end of the 24-hour dosing inte

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 INDERAL LA once daily, whether used alone or added to a diuretic. The dosage ma increased to 120 mg once daily or higher until adequate blood-pressure control is achie The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage o mg may be required. The time needed for full hypertensive response to a given dosa variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERA once daily, dosage should be gradually increased at three to seven day intervals until optim response is obtained. Although individual patients may respond at any dosage level average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few w (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERA once daily. The usual effective dose range is 160-240 mg once daily. The dosage ma increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response obtained within four to six weeks after reaching the maximum dose, INDERAL LA the should be discontinued. It may be advisable to withdraw the drug gradually over a peri several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group ar limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laborat

8833

Ayerst® AYERST LABORATORIES
New York, N.Y. 10017

Frank Y. Watson, M.D. —192nd President

Frank Y. Watson, M.D., will serve as the 192nd President of the Medical Society of New Jersey.

Frank Y. Watson, M.D., of Glen Ridge, will serve as the 192nd President of the Medical Society f New Jersey. Born in Charlotte, North Carolina, Dr. Vatson received his premedical education at Duke niversity and his medical education at the University f Maryland School of Medicine. Following an in-rnship at Charlotte Memorial Hospital, he volun-ered for active duty in the United States Navy. During ie Korean War, he served as a Battalion Medical Of-cer in the First Marine Division and participated in ie numerous military operations of that unit includ-ig the amphibious assault at Inchon, the liberation f Seoul, and the winter offensive into North Korea. For is service, he was awarded a Letter of Commendation y the Secretary of the Navy.

Dr. Watson is certified in anatomic and clinical athology by the American Board of Pathology, having ceived his residency training at Charlotte Memorial ospital. Prior to entering private practice in 1961 in ontclair, he was on the faculty of SUNY-Downstate edical Center serving as surgical pathologist at Kings ounty Hospital. He is clinical associate professor of athology, UMDNJ-New Jersey Medical School. He is a ember of the medical staff of The Mountainside Hos-ital and has been director of the department of athology since 1973.

Since entering practice, Dr. Watson has been very active in various areas of organized medicine. He has served as president of the medical staff and ex-officio member of the board of trustees of The Mountainside Hospital, president of the Essex County Medical Society, delegate to the House of Delegates of the Medical Society of New Jersey, member of the Board of Trustees of the Medical Society of New Jersey, ex-officio member of the Board of Trustees of the New Jersey Hospital Association, and alternate delegate from the Medical Society of New Jersey to the American Medical Association House of Delegates. He is area chairman for New Jersey and Delaware of the Inspection and Accreditation Program of the American Association of Blood Banks.

Dr. Watson especially is interested in political action regarding legislation affecting health care and in the administrative and leadership roles of physicians in the health care system. He has served as chairman of the New Jersey Medical Political Action Committee, and is a member of the American Academy of Medical Directors.

Dr. Watson is married to the former Carolyn D. Wolfe, of Glen Ridge. They met as classmates in medical school, were married shortly after graduation, and have pursued separate medical careers. Carolyn also is certified in anatomic and clinical pathology by the American Board of Pathology, has subspecialized in cytopathology, and is codirector of the division of cytopathology of the department of pathology at Mount Sinai School of Medicine, New York. Her recent appointment as alternate delegate to the American Medical Association House of Delegates by the American Society of Cytology makes the Doctors Watson the only husband-wife team in the American Medical Association House of Delegates.

The Doctors Watson are the proud parents of four children: James, David, Bruce, and Lisa. James and his wife, Marsha, promise to present them with their first grandchild soon. The Doctors Watson also are the proud former foster parents of three Cuban children: Nydia Maciques Webb, and Joe and Matt Borrajero, who as teenagers, escaped from Cuba in 1961. The Doctors Watson enjoy the challenges of the pursuit of their medical careers, and a full and rewarding family life.

The Medical Society of New Jersey congratulates Frank Y. Watson, M.D., and wishes him every success during his term as president.

Kudos to *The Journal*, Its Staff, and Others

The Journal of the Medical Society of New Jersey has been singled out for national commendation from Sandoz, Inc. and from the New Jersey Writers Conference.

For the second year in a row, *The Journal* of the Medical Society of New Jersey has been singled out for national commendation. *The Journal* was granted a Special Award in the ninth annual Sandoz Medical Journalism Competition. A check for $250 and a certificate were presented at the Medical Society of New Jersey's Annual Meeting by a representative of Sandoz, Inc.

At the 17th annual New Jersey Writers Conference on March 24, 1984, *The Journal* was awarded the Author's Citation for "William Carlos Williams: Commemorative Issue" by the Alumni Association of the New Jersey Institute of Technology.

As of January 1984, the American Diabetes Association appointed Arthur Krosnick, M.D., as editor-in-chief of *Diabetes Forecast*, a bimonthly publication for persons with diabetes, their families, and for non-professional readers interested in the subject.

Geraldine Hutner, managing editor of *The Journal*, gave birth to a son (7 lbs. 2 oz., 19½ inches) on March 5, 1984. Gerri and her husband, Jonathan Husch, named their new star Benjamin. Congratulations from us all!

We feel compelled to single out Gerri, Dorothy J. Griffith, and Elizabeth and Joseph Cookson for superb services to *The Journal*. The chairman, Paul J. Hirsch, M.D., and his Committee on Publication have provided guidance at its best, and the Editorial Board, individually and collectively, as well as many ad hoc manuscr and book reviewers, unstintingly have granted exp peer review of all scientific material.

Vincent A. Maressa, J.D., and James E. George, M. J.D., who respectively provide the Membership Nev letter and the Professional Liability Commentary, a collectively prepare the Hospital Governing Boar columns, have done a magnificent job. They are sisted ably by Martin E. Johnson and A. Ronald Rou

We owe a debt of gratitude to President, Dr. Al ander A. Kovacs, Dr. Paul J. Hirsch, Dr. Stanley Bergen, Jr., Gale Wayman, and Dr. David I. Canav for monthly features and columns. Special items a beautifully presented by faculty members of UMD Dr. Richard J. Rapkin and colleagues (Pediatric Brie Dr. Bruce McL. Breckenridge and colleagues (Pharm cological Basis of Therapeutics); and Dr. Herm Baker and colleagues (Contemporary Clinical Nut tion). Numerous book reviewers regularly share th reactions to publications for our readers, and we o them a huge debt.

Finally, I must single out Dr. Avrum L. Katch whose foresight, skill, and judgment, along with u counted hours of reading, writing, telephoning, a editing, made the William Carlos Williams co memorative issue what it was.

Awards go to the Medical Society of New Jersey, a to *The Journal* as a publication. But unrestrict gratitude goes to all the above and more. A

Selection of Blue Cross/ Blue Shield Trustees

VINCENT A. MARESSA, J.D.

Should the selection of Blue Cross/Blue Shield trustees become a subscriber right?

Should the selection of Blue Cross/Blue Shield trustees become a subscriber right?

Recently, Arthur Bernstein, M.D., Secretary of the edical Society of New Jersey, shared with me a copy testimony delivered to a congressional committee viewing federal law on HMOs. The speech was pre- nted by Mary Nell Lehnhard, Vice-President of the ational Blue Cross/Blue Shield Association, on April 1984.

Ms. Lehnhard began by reciting the Blues' allegiance the HMO concept. Then, she proceeded to criticize e HMO Act because it requires a qualified HMO to ve a governing board of which one-third are HMO rollees. Her reasoning is that this requirement uld prevent the Blues from running federally quali- d HMOs and the Blues would have to create separate tities for that purpose.

As a corporate manager and businessman, I under- and what Ms. Lehnhard is saying, but I am not sym- thetic to her position. The requirement that enrol- s have a significant minority position on the govern- g board is a desirable feature. After all, they are pay- g the premiums and should have a say in the man- ement of the companies. I suspect that what really distresses her is the fact that enrollees would have access to data and decisions normally made in secret, but for which they must pay the price. Their access to the data and the right to vote might mean that the professional managers of the Blues would be required to justify their decisions. They simply are not used to functioning in that fashion.

Blue Cross/Blue Shield structure in New Jersey is a case in point. For all practical purposes, they have merged; they cover over three million New Jersey residents. They are an insurance company, but by definition are not either a stock company or a mutual company. In a stock company, the stockholders vote to elect directors and consider annual reports. In a mutual company, the policyholders vote to elect directors and consider annual reports. In the New Jersey Blues, the trustees vote to elect themselves and the "subscribers" as the Blues so fondly call them are without voices and vote. Participating physicians and hospitals are also without voice and vote. The Blues do not hold annual meetings to which subscribers or participating physicians and hospitals are invited.

Isn't it time the Blues gave their "subscribers" an opportunity for an inside view of operations and policy formation?

Doctors: Write your own prescription to cure insurance pains . . .

Rx Prescription

Name MSNJ Member

MSNJ Group
Blue Cross/Blue Shield Major Medical and Dental Insurance

that provides:

- **Flexible plans**
- **Comprehensive benefits**
- **Low, competitive rates**
- **Centralized Administration**

Designed and Administered by
DONALD F. SMITH & ASSOCIATES

Rx Prescription

Name _____

Address _____

Phone _____

Please send more information on the MSNJ

- ☐ Blue Cross/Blue Shield Program
- ☐ Major Medical Program
- ☐ Group Dental Program

Return to:
Donald F. Smith & Associates
One Airport Place, Route 206 North
P.O. Box 2197,
Princeton, New Jersey 08540
(609) 924-8700, (201) 622-6046

AVOID COMPUTER "Down-Time"

On site or carry in servicing for:

IBM PC/XT
Epson Computers and Printers
NEC Computers and printers
Leading Edge Computers
C. ITOH Printers
Comrex printers and monitors

THE SERVICE DEPARTMENT

177 Roseland Ave.
Caldwell, N.J. 07008

(201) 226-7333

SERVICE IS OUR ONLY BUSINESS

Maintenance Contracts Available

HOURS: Mon.-Fri. 7:00 AM-8:30 PM; Sat. 7 AM-6 PM
Save this ad for future reference.

Cost of Medical Care

JAMES E. GEORGE, M.D., J.D.

The newest focus of hospital involvement is the cost of medical services provided in the hospital. Hospital corporations increasingly are concerned with financial matters that were once the sole province of the private staff physician.

Since the mid-1960s, courts across the nation have extended the legal responsibility of the hospital governing board into areas that once were the exclusive domain of the physicians on its medical staff. In many jurisdictions today, the hospital corporation has legal responsibility for monitoring the quality of medical care provided in the hospital. Various quality assurance and peer review programs, and increased scrutiny of appointments to the medical staff, are two examples of increased hospital involvement.

The newest focus of hospital involvement is the cost of medical services provided in the hospital. Responding to pressures from the federal government and the insurance industry, hospital corporations increasingly are concerned with financial matters that were once in the sole province of the private staff physician. A recent Maryland case illustrates this evolving trend.

The case of Ratino *v* Medical Services of the District of Columbia (Blue Shield), 718 F.2d 1260 (1983), involved John Ratino, M.D., a plastic surgeon, who had medical staff privileges at Holy Cross Hospital in Silver Spring, Maryland. Dr. Ratino, who was not a Blue Shield participant, for some time required his patients to sign a written agreement to pay his charges for services to be rendered, the amount to be determined after the medical care was provided. The form Dr. Ratino used provided in part: "It is . . . understood that such fees may exceed amounts allowed by the fee schedules of insurance companies . . . or any other individual or Fee Review Commission not present when the care or surgery is rendered. This specifically includes such fee designations as usual and customary for similar care or surgery rendered by doctors without similar special training. Thus, the patient's liability includes any and all differences between the amounts paid by insurance or other third parties and the fee charged. . . ."

Dr. Ratino used this form in his practice and also used this form when providing care in response to his on-call duty to the hospital's emergency department. The Montgomery County Medical Society received a number of complaints concerning Dr. Ratino's use of this form prior to performing on-call emergency room treatment.

Subsequently, in March 1977, the Montgomery County Medical Society sent a letter to area hospital administrators asking them to suppress such conduct in their emergency departments. The letter did not specifically mention Dr. Ratino.

In response, Holy Cross Hospital advised the Montgomery County Medical Society that the hospital had an "open door" policy with respect to charity care. In 1978, Holy Cross's Executive Committee directed Dr. Ratino to cease using the form in question in the Holy Cross Hospital.

Dr. Ratino then brought legal action in federal court against the hospital, various officers of the Montgomery County Medical Society, and Blue Shield. In his suit, he alleged that Blue Shield's "usual and customary insurance plan" with its provision for Medical Society peer review of medical charges, constituted illegal price fixing in violation of antitrust laws. He also alleged that all the defendants had conspired illegally to restrain him from using his "consent form" in conjunction with providing services in the Holy Cross Hospital.

The United States District Court for the district of Maryland granted summary judgment in favor of all the defendants. It ruled that the form contract used by Dr. Ratino was illegal and in violation of public policy. It also found that Holy Cross Hospital, in directing Dr. Ratino to stop its use, had not reacted to the Medical Society's letter but rather was merely unilaterally carrying out its long established policy of providing care to patients regardless of their ability to pay. The court also found no evidence of anticompetitive purpose on the part of any of the defendants, but rather "an attempt on the part of medical care organizations to implement their own policies aimed at safeguarding the health and welfare of emergency room patients." Dr. Ratino appealed.

The United States Court of Appeals, fourth circuit, upheld the district court in its ruling that the activities of the defendants disapproving Dr. Ratino's use of the form contract did not constitute an illegal conspiracy to restrain trade. The appellate court overruled the district court, however, with regard to Dr. Ratino's al-

*The material for this column is coedited by Arthur Krosnick, M.D., Editor, *The Journal*, MSNJ; Vincent A. Maressa, J.D., Executive Director, MSNJ; and James E. George, M.D., J.D., Director of Professional Liability, MSNJ.

legations of price fixing. It ruled that further legal proceedings were necessary to determine whether the Medical Society's practice of peer reviewing "unreasonable fee" determinations by Blue Shield, in actuality, was illegal price fixing.

The current uncertain climate with regard to insurance and other reimbursement mechanisms, including Medicare, makes it all the more likely that hospitals will involve themselves with the way physicians practice medicine. Hospitals perceive that their financial health, to a greater degree than ever befo is dependent on the activity of the medical staff. Ec nomic realities must be recognized and dealt with both the hospital and the medical staffs.

Whether attempts to resolve differences in this v atile area will result in cooperation or conflict betwe the hospital and the medical staff remains an op question. It sincerely is hoped that these complex pr lems can be mutually negotiated in an evolutiona rather than a revolutionary fashion.

TAX SHELTERS

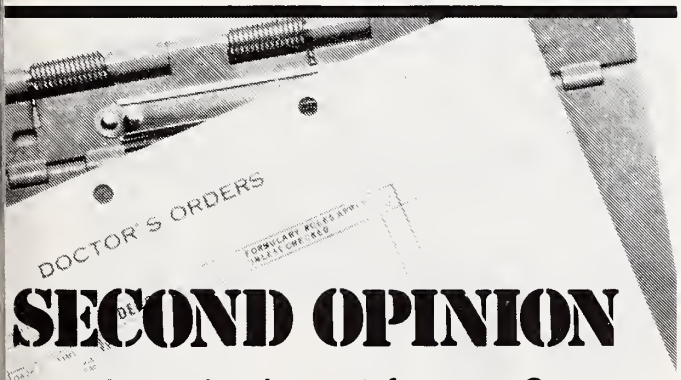
Just one of the personal financial services available to you from the ***physician's bank.***

- tax planning
- lines of credit
- equipment financing
- retirement planning

- money management
- cash flow • investments
- estate planning

Call or Write
Joseph J. Verbaro, Jr.
Senior Vice President
(201) 228-9770

FINTRUST
FINANCIAL AND TRUST SERVICES
DIVISION OF SECURITY NATIONAL BANK & TRUST COMPANY OF NEW JERSEY
101 Eisenhower Parkway
Roseland, New Jersey 07068 Member F.D.I.C.



SECOND OPINION

Leasing's not for you?

ompare these figures (based on a $20,000 vehicle):

UE 1ST DAY	PURCHASE	LEASE*
% sales tax	$1200	$25/mo.
own payment	4000	none
onthly payment	554	410
tal due:	**$5754**	**$435**

So by leasing, you've got $5319 savings on your initial outlay, plus $119 a month, to invest any way you'd like! And insurance is available to qualified N.J. motorists for as little as $600 a year. Call for similar savings on ANY make or model, foreign or domestic. *36-mo/closed-end

value lease inc

Evenings and weekends, call (201) 530-4088

Monmouth St., Red Bank, N.J. 07701 (201) 530-1282

If your professional liability insurance company ran out of money, you could find yourself very much . . .

. . . alone.

We're 6,900 New Jersey physicians insuring *ourselves* through our own non-profit company. If you haven't joined us, you could be more at risk than you know. You owe it to yourself — and those that depend on you — to call us for more information.

800-257-6288

Do it now. Everything is at stake.

A professional service message from the **Medical Inter-Insurance Exchange** of N.J.
Two Princess Road, Lawrenceville, NJ 08648
(609) 896-2404
*"The **Doctors'** Company"*

JMK

BMW

SAAB

Our reputation has been built on our SERVICE



JMK AUTO SALES

391 Rt. 22 (East) Springfield, New Jersey

379-7744

INAUGURAL ADDRESS*

FRANK Y. WATSON, M.D., GLEN RIDGE

Frank Y. Watson, M.D., the 192nd President of the Medical Society of New Jersey, presented this inaugural speech at the Annual Meeting in May.

This is a very special moment for me. I am deeply honored that this House of Delegates has hosen me to be the 192nd President of this dis-nguished Medical Society. I am also most pleased ith the opportunity for service to others this position rovides. Over the years, I have found that helping thers has brought me much pleasure and satisfac-on. For me, the practice of medicine has been one reat love affair, exceeded only by my love for my bride nd medical partner of 35 years. The position of Presi-ent of the Medical Society of New Jersey gives me ndreamed of opportunities to serve the profession I early love. For these opportunities, I thank you from ie very bottom of my heart. I promise you I will give the job my very best efforts. I will need help and I ccept the offer of assistance from Dr. Kovacs.

hroughout the ages, physicians have heard the hallenge:

"Doctor, please do all that you can."

That cry for help is very familiar to you. Each of you as heard it countless times.

It comes from people who are suffering, and deeply arful for their very lives.

It is the ultimate cry for help! Not long ago, this cry or help brought only simple measures of support and ncouragement. There was very little effective treat-ient a physician could give.

In cases of serious illness, the outcome was prompt. Either the patient recovered, or his condition rapidly worsened, and he passed away.

Today, this ultimate cry for help triggers a response that is quantum levels above the response of yesterday.

Over the years, the collective response to that cry has led to the development of the most comprehensive health care system the world has ever known. .

Physicians have provided the leadership; and the American people have provided the resources.

Thousands of modern hospitals have been built in all parts of this country. These magnificent institutions of service to mankind are equipped with the most modern technology our scientists can develop. The pharmacies are cornucopias of medicines so effective, they are called miracle drugs.

Our unsurpassed medical education system has provided over 7 million superbly trained health care professionals that give the very best health care to the vast majority of the 230 million Americans.

Today, Americans are receiving more health care of a higher quality than any people in history. They have less disease, are ill for shorter periods of time, are living longer, and are enjoying a quality of life at a higher level than ever before.

How has this been done? Not by a commitment to cut costs; not by religious dogma; not by governmental

*Presented at MSNJ's Annual Meeting, May 4, 1984.

fiat; not by competition of the sort found in the commercial marketplace.

It was done by cooperation and teamwork! Yes, cooperation among the many parts of American society: The medical profession, the scientific community, our religious institutions, our educational institutions, our business community, and yes, even our government.

Banded together as a team, they identified their mission, defined the goals necessary to achieve that mission, and then worked cooperatively doing what each does best to build the most effective health care system that man has so far devised.

That, I like to think, is the American way.

And I repeat, the resources for all of this have been willingly provided by the American people; 321 billion dollars (10.5 percent of our GNP) are devoted to health care each year. Health care has become our third largest industry.

The guidelines for this great achievement were simple, direct, and exactly what you would expect.

The mission was to free our fellow men of all preventable and curable disease.

The attainment of this mission was to be through the pursuit of four goals.

Goal 1 was to prevent disease wherever we can.

Goal 2 was to cure disease whenever possible.

Goal 3 was to provide humane care and comfort to all of our people with yet incurable diseases.

Goal 4 was to continue, with all possible speed, research into the causation, cure, and prevention of the still incurable diseases.

We have made considerable progress, but we still have a long way to go. In moments when things are not going well, I sometimes wonder if a world free of disease is really achievable!

Then I think of the eradication of small pox and my optimism returns!

With the capacity and the momentum now in our health care system, I believe we are on the verge of unprecedented progress in the eradication of diseases affecting mankind. To interfere with this at this time would be a blunder of historic dimensions.

As American citizens, we all can take pride in this accomplishment, viewing it not only as very sound stewardship of the vast wealth with which this nation is blessed, but also pointing to it as yet another example of what free people in a democratic society can achieve.

And yet as physicians we recognize that there is still much to be done.

We recognize that there are still many Americans who do not have equal access to the superb health care services now available to the vast majority of Americans. This is curable and I am confident it will be.

We recognize that there are still many diseases for which we have no satisfactory treatment; and that the humane supportive care of people with these diseases is enormously expensive. This is money well spent until our research efforts can bring relief.

We recognize that there are many diseases that are absolutely preventable and yet they continue to occur with alarming frequency and consume enormous amounts of the resources allotted to health care. This is a major challenge to our public health system. Increased efforts would minimize this situation.

We recognize that the choice of unhealthy lifestyle by all too many Americans results in the occurrenc of many of these absolutely preventable diseases, an accounts for a significant part of the cost of healt care. This is a major challenge to both our publi health and our educational systems.

We recognize that an increasing number of Ameri cans are living longer than ever before and are reach ing the ages at which health care consumes a dis proportionately large amount of national resources with a disappointingly small return in longevity an increased quality of life.

The solution to this problem is a challenge of im mense dimensions that requires the combined effort of all segments of society.

While recognizing that the American people hav made a greater effort and have achieved more than an other people in the pursuit of that ultimate dream o all men, a world free of disease, we are very much awar that the continuing increase in the cost of this pursui has attracted the interest and concern of leaders in a segments of our society.

We are now faced with allegations of duplicatior excessive utilization, and gross inefficiencies in th health care system. This frequently is referred to as fa that must be rendered from the system as fat i rendered from pork in the making of lard.

With such vague, unclear, and often inaccurate view of the conditions in the health care system, a whol spectrum of solutions to these alleged problems ar being foisted upon us.

I am particularly concerned when solutions tend t be riflelike in approach aimed at only one aspect of th problem.

An example of the basis for my concern are som remarks by Governor Kean at the First Session of th National Governors Association Winter Meeting, Feb ruary 26, 1984.

His remarks dealt almost exclusively with the cost of health care services and their alleged negative im pact on federal and state budgets, on the America economy, and on the cost of doing business in th United States. The Governor stated; "If American busi ness is to sustain our economic recovery, if busines is to put our workers back to work, then we must brin health care costs under control." The Governor wa strangely silent about the fact that health care in th United States is the third largest industry and one o the top three in New Jersey. Over 7 million healtl professionals provide health care to the 230 millio Americans. Another 14 million Americans play a sup porting role to those 7 million health professionals While there may be some negative aspects regardin health care costs, and while economic benefit is cer tainly not the primary reason for having a health car industry, the economic impact of an industry provid ing employment either directly or indirectly to 2 million Americans should at least be acknowledge and placed in perspective, in any discussion of th impact of health care on the American economy.

The Governor also shared some points he learned a a hearing of health financing experts that he and Gov ernor Lamm, of Colorado, convened in December.

Governor Kean reported: "Of the projected increas

n costs of health care by 1990, 57 percent will be due o general inflation, 7 percent due to medical care infla- ion, and 8 percent due to population increases. That eaves 28 percent due to changes in medical technology nd patient care use and treatment practices. If we are o have any impact, it will be on this 28 percent of the ncrease."

He then commented at length on several ways to mpact on the 28 percent due to changes in medical echnology and patient care use and treatment prac- ices. The ways discussed included controlling high echnology (CAT scanners and NMRs), controlling low echnology (routine lab tests and procedures and rugs), and controlling the number of physicians and heir specialization. All of the discussion dealt with the eduction of costs. No comment regarding the allevia- ion of illness was made and there was no mention as o what might be done to impact on the 57 percent f the increase in health care costs due to general nflation, an area that is much more in the realm of overnment than any medical matters he mentioned.

The Governor's comments regarding the problem of he number of physicians and their specialization is s follows:

"Our biggest problem is not numbers, but the fact hat fully 85 percent of physicians are specialists, a evel higher than any other country in the world. These re the doctors using high technology—often, in fact, efined by that technology. One of our witnesses in the ecember hearing found that a general internist can riple his net income if he has a heavy, but justified aseload of routine EKGs, chest x-rays, lab tests, and igmoidoscopies, compared to colleagues who did none f these, but saw 15 percent more patients. ynecologists, urologists, and gastroenterologists earn to 12 times as much per hour when they use their echnologies.

"Given these incentives, is it any wonder that our edical system performs more surgery and invasive iagnostic procedures than any other country in the orld? One witness said in December, 'There are not nough coronary arteries for the cardiologists.'"

These comments with their obvious inconsistencies how a gross lack of understanding of the subject. It sobering indeed to realize that those comments were ade by the Governor of our state.

Now it is not my intent to take the Governor to task day regarding his remarks at the National Governors ssociation Winter Meeting. This is not the proper rum, and furthermore, the Governor is not here. uch matters are best dealt with face to face.

By referring to the Governor's remarks, however, I ave tried to make the point that the provision of ealth care is being discussed in forums other than edicine, by persons other than health professionals, ho often have a mission and goals different from ose of the medical profession, and who frequently ave enormous power, which they are not averse to sing to deal with problems as they see them in the health care system.

It, therefore, is necessary for us, as physicians, to not only "do all that we can" to provide the very best of health care possible in the one-on-one doctor/patient relationship, we must also, "do all that we can" to be a part of all discussions and all decisions regarding health care wherever those discussions are being held and wherever those decisions are being made.

"To do all that we can" also means we must learn our way around in the political arena, the halls of government, the boardrooms of industry, and the domain of the health care administrators, for it is in those forums that the major decisions regarding health care are now being made.

Such opportunities are occurring with increasing frequency. We must seize those opportunities and make the most of them. Communication between the Medical Society, various agencies of government, business, and health care institutions is steadily growing. There are now frequent contacts with the Commissioner of Health, the Health Department, members of Legislature, the Governor's Office, the State Board of Medical Examiners, the New Jersey Hospital Association, and the New Jersey Business Group.

In addition, more than ever before physicians are working with administrators in hospitals, HMOs, PPOs, and other health-related facilities as well as with representatives of other groups of the American people. The efforts of the American Medical Association to develop a health policy agenda for the American people is a prime example of such teamwork.

When challenged to "do all that we can," we must always remember (we must never forget) that as physicians, we are the primary advocate for our patients, not only at the bedside and in our office, but also in all places where the discussions and decisions regarding health care are held and made.

As the primary advocate for our patients, we must support those actions that advance our mission and our goals, and we must vigorously oppose those actions that endanger our mission and our goals.

In closing, I repeat: I believe the mission of the medical profession is to free people of all preventable and curable diseases.

I also believe that to accomplish that mission, we must continue to pursue four goals, all of which have stood the test of time.

Goal 1 is to prevent disease wherever we can.

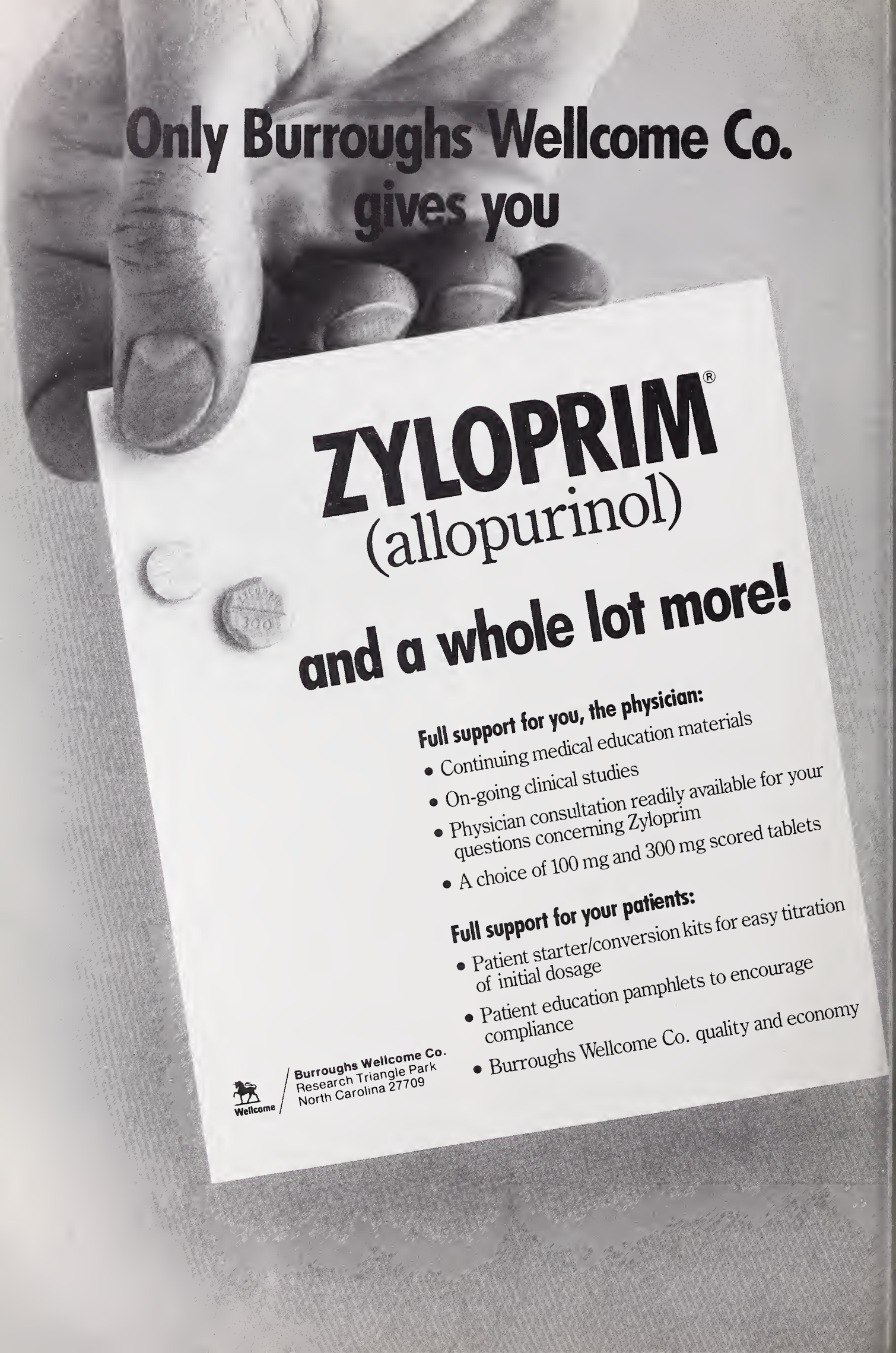
Goal 2 is to cure disease wherever possible.

Goal 3 is to provide humane care and comfort to all of our people with yet incurable diseases.

Goal 4 is to continue with all possible speed, research, and development into the causation, cure, and prevention of those diseases still unconquered.

I believe that we will continue to have the full support of the American people so long as they know and believe that we are fully committed to that mission and these goals. Let us never leave them in doubt!

"Doctor, please do all that you can."


Only Burroughs Wellcome Co.
gives you
ZYLOPRIM®
(allopurinol)
and a whole lot more!
Full support for you, the physician:
• Continuing medical education materials
• On-going clinical studies
• Physician consultation readily available for your questions concerning Zyloprim
• A choice of 100 mg and 300 mg scored tablets
Full support for your patients:
• Patient starter/conversion kits for easy titration of initial dosage
• Patient education pamphlets to encourage compliance
• Burroughs Wellcome Co. quality and economy
Wellcome
Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Farewell Address: An Accounting of My Stewardship*

Alexander D. Kovacs, M.D., Scotch Plains

This address is an accounting of his stewardship, as Alexander D. Kovacs, M.D., completes his year as President of the Medical Society of New Jersey.

According to St. Luke, Chapter 16, a certain rich man called upon his steward thus, "Make an accounting of thy stewardship for thou canst be steward no longer."

I no longer can be your steward, and so I shall make my accounting. There are so many things to do as President of a state medical society that the momentum can spin you in an endless circle unless you make it go in one direction. The direction I chose to carry out my stewardship was to attempt to rally the members into a unified whole.

I wish I could say that I succeeded 100 percent, but, I did not. There has been some pretty creditable movement, however.

This past year we collected more money for political campaigns than ever before and we were noticed in state politics. This year we introduced a package of legislation which, if passed, will begin to correct some of the inequities of the present professional liability situation. At least now we are in a position to talk to some of our legislators about these bills. No one is so naive as to believe that a campaign contribution buys a politician's vote. What it does get you is an opportunity to present your case. We have a good case and a good opportunity. Let us not waste it. We now must concentrate our efforts on this package of bills and not fragment our energies on other less important legislation. Don't forget, these politicians have other interests besides our bills. We should be interested in and support some of their other efforts if we are to hope for their support for our package.

We also managed to stick together long enough to prevent a fee schedule from being imposed upon us as part of the latest auto insurance law in New Jersey; and we certainly have stuck together, I am proud to say, on the issue of a voluntary freeze on fees. The positive reaction to that request on the county, state, and national level has been outstanding.

Concerted action by the AMA and by doctors all over the country has brought about the defeat of the nefarious Rostenkowski amendment in Congress. If we had lost that fight, we would have lost the right to practice in our own hospitals.

Those were some of the battles we won. We have had some losses too. Disciplinary actions by hospital governing boards as well as malpractice awards must be reported to the State Board of Medical Examiners.

One year ago we were involved in a discussion with the government on how best to treat the indigent patient. We still are. They keep coming up with ideas like capitation, and we keep talking about the high price of emergency room care, and the beautiful simplicity of a modest but respectable fee for the private sector.

We have not yet spoken with one voice on the whole

*Presented before the House of Delegates at the Annual Meeting, May 4, 1984, Atlantic City.

new structure of medical care which has grown so visibly in New Jersey this past year—the freestanding urgicenters, surgicenters, and hospital satellites. We almost seem to be paralyzed by these new developments. This is no time to stand around open-mouthed; while we do, others are making the regulations and administrative decisions. We have to find a method to handle these alternate care entities which will be in the best interests of our patients, or we will not have any patients to worry about.

There is so much that needs to be done. One year is not enough to accomplish solid results. There is not enough time to bring developing relationships into bloom. I believe one year was fine in the days when we were not so constantly under the gun. But in today's climate, some consideration should be given to making the presidency a two-year term.

I do have some confidence that good foundations have been laid for continuing negotiations with the various agencies and entities involved in our professional lives.

Our relationship with the New Jersey State Board of Medical Examiners is less hostile than it used to be. There continue to be differences—it is not possible for an organization whose purpose is physician advocacy always to be in tune with an organization whose purpose is physician regulation. The present problem regarding the scope of practice for chiropractors is an illustration of that occasional disharmony.

Also, we have achieved some measure of respectability in the eyes of the New Jersey State Department of Health. We cannot, of course, take all the credit for that. Commissioner Goldstein certainly has done his share to keep the lines of communication open. On our end, there has been a significant effort to serve on committees with Health Department personnel as we grope together toward solutions for some very tough problems. While we may not be singing the star role, at least we have moved out of the chorus.

I submit to you, my friends, that the future of our profession lies in our willingness to recognize the legitimate interests of others in the health care business. We cannot agree with everything they propose but we have to be willing to work with them if we expect them to agree with anything we propose.

One of the most rewarding of the presidential duties is the opportunity to visit with you on your home grounds. I wish to thank all of the county societies who invited me to attend their meetings. In every county I found some concerned, aware physicians. I wish there were more. The biggest problem this profession has is the apathy of its members. I was chagrined to find how many physicians fail to appreciate the seriousness of our problems and to accept that they individually and collectively have a role to play in their solutions—and that role comes to something more than maintaining the status quo and complaining about their leaders I know you share my concern about these determinedly uninformed.

There are serious problems to be faced. We canno hide from them. They leap out from every newspape and television set. We must try to help cope with th rising cost of care. We have to have the courage to tel people that costs will continue to rise despite fe schedules or fee freezes until this country accepts th plain fact that increasing numbers of elderly patient cannot be treated with the full range of medical tech nology without increasing costs.

We must face the problem of providing medical car for the least fortunate among us, and we must tell th story of the thousands of hours of free care we alread contribute.

We must face the problem of the increased numbe of young physicians who have a right to expect to mak a living after years of study and sacrifice. We must no turn our backs on these men and women.

None of these problems have been neglected durin this past year, but they require endless effort and dedi cation if solutions are ever going to be forthcomin We must all continue actively to support our leader as they struggle to find answers to these and a hos of other difficult issues.

When I became president I had the good fortune t succeed Howard Slobodien, M.D. I wish to publicl thank Howard for being a staunch supporter an friend this past year. I hope I will be as helpful to Dr Watson. Dr. Costabile served ably as chairman of th Board of Trustees, and I wish to acknowledge his as sistance.

There are others I wish to thank, not so much fo what they did for me, but for what they did for you the entire Board of Trustees and other members o councils and committees who gave up their Sunday and their days off to come to Lawrenceville. Withou the dedication of these few, we would not survive a a profession. You owe them more than you can eve repay.

Thanks is also due to a truly remarkable staff. Vin cent Maressa is one of the most respected executiv directors in the United States. He makes you proud t come from New Jersey. The value of people like Dian Gore, Marie Fisher, and Eileen Pfeiffer to our pro fession and our Society cannot be measured.

My personal thanks to that most gracious of ladies Ida, my wife. She has been cheerful and charmin through this busiest of times, and I can only humbl acknowledge how much I owe to her patience and goo humor.

Finally, I thank you, the delegates, for the opportuni ty to serve as your President.

Grace Scribner Gellman is the 58th President of the Medical Society of New Jersey Auxiliary. he assumed leadership of the Auxiliary on May 5. ormerly Grace Scribner, a graduate of the Aultman ospital School of Nursing, Canton, Ohio, Mrs. ellman attended Ohio University, Athens, and Kent tate University, Kent.

She married the late William B. Gellman, M.D., after e finished his internship at Aultman Hospital. He tarted his general practice and surgery in Wood-Ridge nd was affiliated with Beth Israel Hospital, Passaic, nd South Bergen Hospital, Hasbrouck Heights.

Dr. and Mrs. Gellman worked as a team in the early ears of their marriage in addition to raising three hildren—Alexander C., a urologist in Denville; Michael ., an aerospace engineer and naval aviator who urned to medicine and is finishing his residency in nesthesia; and Mrs. Martha Braff, a biology major om Skidmore College, Saratoga, now living in Pittsord, New York, where her husband, Steven P. Braff, I.D., practices radiology.

Grace has been involved in volunteer and organizaon work for many years. She was a charter member f the South Bergen Hospital Women's Guild and erved as its first president. She was active in the ergen County Medical Society Auxiliary, serving in its arious chairmanships and offices to become president during 1973 to 1974. At present, Mrs. Gellman erves on the Board of Governors of South Bergen ospital as Vice-President; is a member of the National ssociation of Parliamentarians; and belongs to the alisadium Unit in Bergen County. As a member of the Iedical Society of New Jersey Auxiliary, Grace has erved as liaison representative to the University of Iedicine and Dentistry of New Jersey and Volunteer riendly Visitors; Chairman of AMA-ERF; Recording ecretary; Vice-President; and President-Elect.



Mrs. William B. Gellman

Golden Merit Awards

At ceremonies held on May 4, 1984, during the 218th Annual Meeting of the Medical Society of New Jersey, Resorts International, Atlantic City, the following received MSNJ's Golden Merit Award indicating they held the degree of doctor of medicine for 50 years.

Atlantic County
Samuel M. Diskan, M.D. ..... Temple '34
Werner Hamburger, M.D. ..... Berlin '34
J. Neafie Richardson, M.D. ..... Temple '34

Bergen County
Roslyn Barbash, M.D. ..... Bellevue '34
Kalman Chase, M.D. ..... Syracuse '34
William D. Deuell, M.D. ..... Columbia '34
Joseph Greenbaum, M.D. ..... Long Island '34
Rev. Edmund E. Jacobitti, M.D. ..... Temple '34
Emil Joseph Kakascik, M.D. ..... Syracuse '34
Kenneth S. Landauer, M.D. ..... Johns Hopkins '34
Samuel N. Lipsett, M.D. ..... George Washington '34
Samuel G. Loman, M.D. ..... Glasgow '34
Edward M. Mancene, M.D. .... New York Medical '34
Robert J. Neville, M.D. ..... Long Island '34
Nelson C. Policastro, M.D. ..... Rome '34
Jacob Prager, M.D. ..... Columbia '34

Burlington County
Maurice Lev, M.D. ..... Creighton '34
Paul Reed Sparks, M.D. ..... Pennsylvania '34
John Carl Voss, M.D. ..... Temple '34

Camden County
Nathan Asbell, M.D. ..... London '34
Francesco D'Imperio, M.D. ..... Hahnemann '34
Paul Mecray, Jr., M.D. ..... Pennsylvania '34
Edwin R. Rosner, M.D. ..... Vienna '34

Cape May County
Jules Cooper, M.D. ..... Maryland '34

Cumberland County
Nicholas Edward Marchione, M.D. ..... Hahnemann '34

Essex County
Frank G. Barnard, M.D. ..... Hahnemann '34
Irving V. Berney, M.D. ..... Western Ontario '34
Bernard Bolten, M.D. ..... St. Louis '34
Louis A. Brodkin, M.D. ..... George Washington '34
Richard H. Bruning, M.D. ..... Columbia '34
Alton E. Bythewood, M.D. ..... Meharry '34
John A. DeVivo, M.D. ..... Georgetown '34
Robert F. Dow, M.D. ..... Georgetown '34
Robert E. Fullilove, Jr., M.D. ..... Howard '34
Frank M. Galioto, M.D. ..... New York Medical '34
Joseph Gamba, M.D. ..... St. Louis '34
E. Leslie Gaylor, M.D. ..... Tufts '34
Jerome Gelb, M.D. ..... Maryland '34
Frank Giuffra, M.D. ..... Long Island '34
Jesse T. Glazier, M.D. ..... Hahnemann '34
Andrew J. V. Klein, M.D. ..... Edinburgh '34
Henry H. Kosterlitz, M.D. ..... Breslau '23
David B. Meisel, M.D. ..... New York Medical '34
Irving Ocheret, M.D. ..... George Washington '34
Patrick J. Romano, M.D. ..... Georgetown '34
Victor Rudomanski, M.D. ..... Long Island '34
Thomas A. Santoro, M.D. ..... Jefferson '34
Richard H. Smith, M.D. ..... Virginia '34
John J. Torppey, M.D. ..... Georgetown '34
William R. Ward, M.D. ..... Cornell '34

Hudson County

rank R. Arndt, M.D. ..... New York University '34
rban R. Bigliani, M.D. ..... Loyola '34
lilton Blum, M.D. ..... Georgia '34
dolph D. Casciano, M.D. ..... Columbia '34
Villiam Feller, M.D. ..... George Washington '34
dward D. Fenimore, M.D. .... New York Medical '34
ohn G. Imhoff, M.D. ..... Georgetown '34
lement M. Jones, M.D. ..... Howard '34
amuel Penchansky, M.D. ..... California '34
avid B. Simpson, M.D. .... New York University '34

Mercer County

oseph K. Bayne, M.D. ..... Hahnemann '34
. Yale Byer, M.D. ..... Georgetown '34
oseph Robert Deitz, M.D. ..... Maryland '34
avid A. Fluck, M.D. ..... Hahnemann '34
vin Levy, M.D. ..... Georgetown '34
amuel Joseph Lloyd, M.D. ..... Johns Hopkins '34
idor Markowitz, M.D. ..... St. Louis '34
ouis Rampona, M.D. ..... Rush '34

Middlesex County

lichael Brody, M.D. ..... Cornell '34
vin J. Fine, M.D. ..... George Washington '34
ollins E. Lewis, M.D. ..... Meharry '34
Villiam F. Murray, M.D. ..... Long Island '34
an B. Smith, M.D. ..... Pennsylvania '34
idney Tucker, M.D. ..... Bellevue '34

Monmouth County

amuel Bar, M.D. ..... Jefferson '34
avid I. Diamond, M.D. ..... George Washington '34
ohn William Hardy, M.D. ..... Hahnemann '34
tto Lehmann, M.D. ..... Berlin '34
oseph F. Raffetto, M.D. ..... Georgetown '34

Morris County

lvin A. Rosenberg, M.D. ... New York University '34
Merlin T. Ryman, M.D. ..... Pennsylvania '34

Ocean County

Clinton Ridgway Schneider, M.D. .. Hahnemann '34
E. Charlotte Seasongood, M.D. ..... Woman's Medical '34

Passaic County

Sidney Gelman, M.D. ..... Maryland '34
Harry Katz, M.D. ..... Rush '34
Joseph M. Keating, M.D. ..... Georgetown '34
Walter A. Kovaleski, M.D. ..... Boston '34
Morton Kulick, M.D. ..... New York University '34
Stephen M. Liana, M.D. ..... St. Louis '34
William Paris, M.D. ..... Indiana '34
Theodore C. Sabarese, M.D. ..... St. Louis '34
Andrew Sporer, M.D. ..... Hungary '34
Leonard J. Trilling, M.D. ..... Columbia '34
Ralph Cady Yeaw, M.D. ..... Rochester '34

Salem County

J. Robert Cox, M.D. ..... Hahnemann '34

Somerset County

Anthony J. Allegrante, M.D. .. New York Medical '34
Nicholas A. Falcone, M.D. ..... Jefferson '34
Alan J. Stolow, M.D. ..... London '34

Union County

Herbert E. Jones, M.D. ..... Long Island '34
Junius T. Langston, M.D. ..... Howard '34
Evert A. Larsson, M.D. ..... Kansas '34
James H. Maroney, M.D. ..... Columbia '34
George H. Marts, M.D. ..... Kansas '34
William C. Meineke, M.D. ..... Hahnemann '34
Michael Taranto, M.D. ..... Georgetown '34
John Trano, M.D. ..... Rome '34
Richard Wagner, M.D. ..... Maryland '34
Albert I. Whitken, M.D. ..... Jefferson '34


Just once each day...
First-step blood pressure control with optimal simplicity
Benefits diuretics cannot offer . . . Once-daily INDERAL LA (propranolol HCl) provides smooth, 24-hour control of blood pressure plus the cardiovascular benefits of the world's leading beta blocker. And INDERAL LA provides a high degree of patient acceptance—without potassium problems.
Experience no other beta blocker can match . . . Once-daily INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.



Start with 80 mg once daily... Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



80 mg 120 mg 160 mg

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories

Just once each day for initial therapy in hypertension.

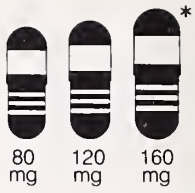
Ayerst®

Just once each day for initial therapy in HYPERTENSION.

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL™ LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.
INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.
INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.
The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.
In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.
In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.
The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.
Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.
Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.
Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.
Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.
Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.
IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.
INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.
DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.
THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.
IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.
Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.
Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.
DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.
Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dose levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.
Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.
There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.
Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.
Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.
Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.
Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.
Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.
Respiratory: bronchospasm.
Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.
Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.
Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.
HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.
ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.
If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).
MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.
HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.
PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are limited to permit adequate directions for use.
*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.
8950/2

Ayerst AYERST LABORATORIES
New York, N.Y. 10017

Cardiac Amyloidosis And Idiopathic Hypertrophic Subaortic Stenosis

Richard A. Daniels, M.D., Ronald Weinberg, M.D., Anis F. Rangwala, M.D., Gary Mintz, M.D., Long Branch*

Our patient with hypertrophic subaortic stenosis and multiple myeloma developed chest pain, pulmonary edema, and syncope. Postmortem examination revealed cardiac amyloidosis with involvement of coronary microvasculature and hypertrophic subaortic stenosis. Abnormal hemodynamics of these diseases were complementary and clinically fatal.

Our understanding of recent therapeutic advances in the treatment of idiopathic hypertrophic subaortic stenosis greatly has improved the morbidity and perhaps decreased the mortality of this disease. Described anatomically in 1958 by Teare,[1] the condition has been known in Britain as hypertrophic obstructive cardiomyopathy and in Canada as muscular subaortic stenosis.[2]

We present a man who had idiopathic hypertrophic subaortic stenosis, multiple myeloma, and cardiac amyloidosis. We believe the abnormal hemodynamics of each of these diseases was additive and resulted in a poor prognosis.

CASE REPORT

In February 1980, our patient, a 47-year-old male, complained of typical angina pectoris. On physical examination, the carotid upstroke was noted to be brisk bilaterally; no bruits were audible. No jugular venous distension was noted. The first and second heart sounds were normal and a 2/6 systolic murmur at the apex increased with standing and during the strain phase of the Valsalva maneuver. Lung fields were clear and there was no pedal edema.

Electrocardiogram was normal. A real-time, two-dimensional echocardiogram (Figure 1) revealed localized hypertrophy of the proximal septum, vigorous wall motion with systolic cavity obliteration, and left atrial enlargement. There was no evidence of systolic anterior motion of the mitral valve at rest. A technetium gated scan with exercise demonstrated normal wall motion and an ejection fraction of 62 percent. A diagnosis of idiopathic hypertrophic subaortic stenosis was made and propranolol was prescribed with major symptomatic improvement. In April 1981, recurrent chest discomfort prompted a thallium-201 exercise test. This demonstrated a perfusion defect at the height of exercise in the interventricular septal area; the defect normalized at rest.

Cardiac catheterization was performed while the patient was taking 160 mg per day of propranolol. The left ventricle was entered via the transatrial septal technique. Using equisensitive transducers and simultaneous left ventricular and aortic pressures, there was no resting gradient. During isoproterenol infusion, the heart rate rose from 60 to 110 per minute, and a 54 mm/Hg gradient was observed after a premature ventricular contraction.

Coronary angiography revealed normal coronary arteries. The left ventriculogram demonstrated vigorous contraction with normal cavity size. An incidental

*From the Departments of Medicine and Pathology, Monmouth Medical Center, Long Branch, and the Likoff Cardiovascular Institute, Hahnemann Medical College and Hospital, Philadelphia. Correspondence may be addressed to Dr. Daniels, Monmouth Medical Center, Long Branch, NJ 07740.

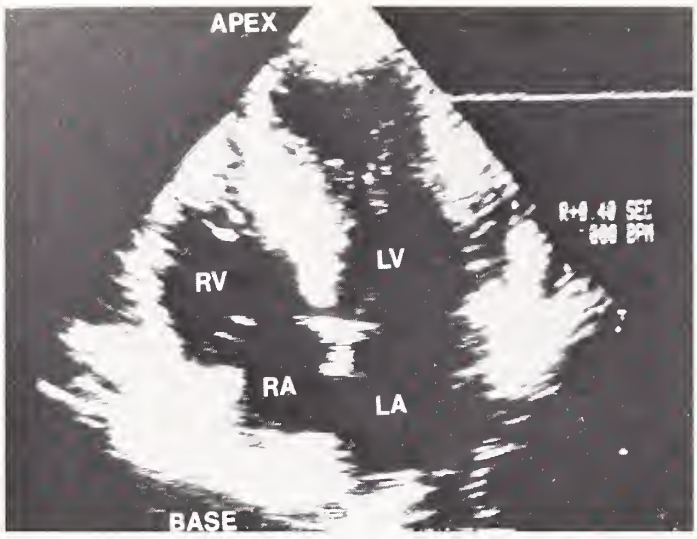


Figure 1—Real-time, two-dimensional echocardiogram (apical four-chamber view) showing hypertrophied interventricular septum. LA = left atrium; LV = left ventricle; RA = right atrium; RV = right ventricle.

serum hyperproteinemia was noted and further evaluation revealed an IgA lambda paraprotein with supression of IgM on immunoassay. Bone marrow aspiration revealed increased plasma cells (15 percent) with immature binucleated cells present. A diagnosis of multiple myeloma was made. There were no clinical manifestations of extracardiac amyloidosis.

The patient was hospitalized in December 1981 and January 1982 for pulmonary edema and chest pain; he was treated with furosemide and propranolol with good response each time. Electrocardiogram at that time demonstrated normal sinus rhythm at a rate of 82 beats per minute with left axis deviation and Q waves in III, AVF, V1-V3. Nonspecific ST and T wave changes were present. CPK-MB fractions were normal. He was discharged and advised to take propranolol 80 mg daily and furosemide 80 mg daily.

In February 1982, the patient came to the emergency room after a syncopal episode and complained of severe substernal chest pain and shortness of breath. He was in cardiogenic shock and pulmonary edema. His electrocardiogram revealed an intraventricular conduction defect of the left bundle-branch block type with nonspecific ST and T wave abnormalities.

Resuscitative measures including intubation, intravenous fluids, and vasopressors (dopamine and norepinephrine) failed to help and the patient expired in electrical-mechanical dissociation.

POSTMORTEM RESULTS

Postmortem examination revealed a heart weight of 550 gm and a disproportionate increased thickness of the interventricular septum (maximum thickness 2.2 cm) as compared to the posterior wall. Histological examination showed muscle fiber hypertrophy, focal interstitial fibrosis, cytoplasmic vacuolar degeneration of muscle cells (Figure 2), and bizarre muscle nuclei. Despite the absence of evidence of abnormal or whorled arrangement of muscle fibers, these changes are consistent with hypertrophic cardiomyopathy. There was no evidence of acute myocardial infarction. In multiple areas, small interstitial arteries and arterioles show homogeneous deposits in their walls which stained positively for amyloid (Figure 3). A few minute



Figure 2—Section from the heart showing cytoplasmic vacu lar (↑) degeneration and hypertrophy of muscle ce (hematoxylin-eosin stain X 50).

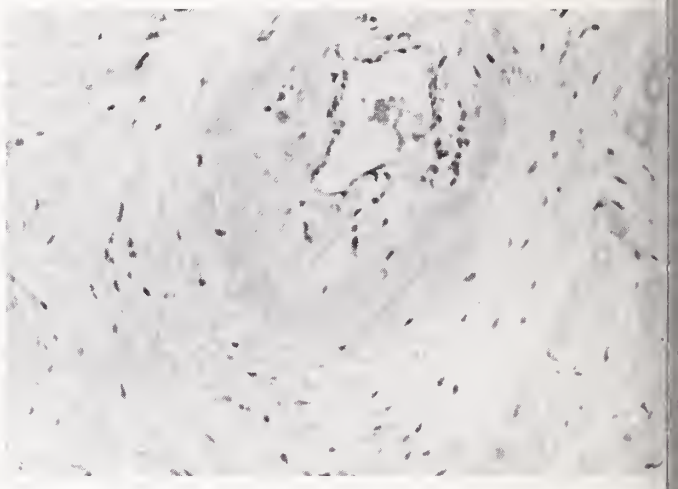


Figure 3—Section from heart showing homogenous depos in the wall of the interstitial arteries which stained amyloid (congo red stain X 50).

interstitial deposits of amyloid also were present extr vascularly in the epicardium and the subendocardiur Myeloma cells were not seen in any of the numerou sections of the heart. The right and the left corona arteries showed minimal arteriosclerosis.

Outside of the heart, there was evidence of residu multiple myeloma involving the left fourth and eight ribs and multiple vertebral bodies. Finally, foc amyloid was present in the bone marrow and al involved the microvasculature of the lungs, stomac urinary bladder, and periadrenal connective tissue.

Acute massive pulmonary edema was the immedia cause of death.

DISCUSSION

The association of amyloidosis with multip myeloma was first reported by Hildebrand in 189 More recently, studies have confirmed that prima amyloid fibrils frequently are derived from lambd light chains of immunoglobulins.[3] The mean age patients with multiple myeloma associated wi cardiac amyloidosis is 60 years old.[4] The media survival after diagnosis is 20 months with the usu survival after histologic diagnosis of cardiac amylo of 2 to 4 months.

The presenting manifestation of cardiac amyloidos is congestive heart failure, although ischemic hea disease from amyloidosis of intramyocardial arteri

as been reported and may cause angina pectoris and ıtractable congestive heart failure. Cardiac ar-ıythmias, both ventricular and supraventricular, are ɔmmon particularly in patients taking digitalis. inus node infiltration resulting in supraventricular rhythmias explains the heightened sensitivity to igitalis.

The modalities which strongly suggest the diagnosis cardiac amyloidosis include M-mode and two-mensional echocardiography, electrocardiography, ronary angiography, and ventriculography. En-ɔmyocardial biopsy may confirm the diagnosis.

Echocardiographic criteria include symmetrical in-ease of left ventricular wall and septal thickness, minished or absent systolic movement of both the ptum and left ventricular wall, and diminished left ntricular contraction resulting in generalized pokinesia and reduced cardiac output. The use of o-dimensional echocardiography has demonstrated ickened cardiac walls with a "granular sparkling" ɔpearance and may be virtually diagnostic. Quan-tative M-mode echocardiography may reveal charac-ristic findings among which are normal left ven-icular cavity size, decreased peak rate of diastolic vity filling and prolongation of isovolumetric con-action. The data indicate that cardiac amyloidosis is anifest initially as diastolic dysfunction.[5] Echo-rdiographic muscle cross-sectional area tends to be creased and there is an inverse correlation between ectrocardiographic voltage and muscle cross-sec-ɔnal area.[6]

On electrocardiogram, voltage in the precordial leads ave in V5 and V6 usually is less than 15 mm.

A low cardiac index and marked elevation of the ght and left atrial, and right and left ventricular end astolic pressures are all encountered in cardiac nyloidosis.

Death in cardiac amyloidosis may be due to intrac-ble congestive heart failure. Thirty percent of pa-nts with primary amyloidosis died suddenly, esumably of a cardiac arrhythmia.[7] The elec-ɔcardiogram in many of these patients revealed con-uction defects or a spurious "myocardial infarction" ttern. The chest pain most likely is due to amyloid filtration of the small intramyocardial arteries, hich are too small to be visualized by angiography. There is no therapy at present for cardiac nyloidosis, except to control the abnormal plasma cell ɔne which produces the light chain protein respon-ɔle for the amyloid fibril deposition.

The importance of percutaneous endomyocardial opsy is clear because of its relative ease and safe-[8,9] as well as its role in discriminating between nyloidosis and other forms of restrictive heart dis-se.[10]

Hypertrophic subaortic stenosis is manifested thologically by asymmetric hypertrophy of the inter-ntricular septum. Histologically, disordered arrange-ents of septal myofibrils account for the inter-ntricular septal hypertrophy. Typical hemodynamic ndings are reduced left ventricular compliance and dynamic left ventricular outflow tract gradient.

The relative compensation of the patient prior to the set of cardiac amyloidosis is of note in the case presented. As in most cases of hypertrophic cardiomyopathy, his systolic ventricular function was excellent as manifested by a high ejection fraction and vigorous left ventricular contraction with normal cavity size on ventriculography. In this disease, abnormal diastolic function is the rule with diastolic stiffness of the ventricle causing poor early diastolic filling. The ventricle may not be relaxed enough to accept the return from the pulmonary veins during diastole causing a rise in pulmonary pressure and pulmonary edema even through the vigor of contraction is excellent. Syncope may occur during volume depletion.

The mainstay of therapy in idiopathic hypertrophic subaortic stenosis is beta blockade. This may be useful in reducing chest pain, palpitations, and possible syncope.[11] More recent studies have shown that verapamil can reduce left ventricular outflow obstruction,[12,13] increase exercise capacity,[14] and reduce symptoms.[15] However, verapamil has been reported to cause pulmonary congestion and must be used with caution.[16]

Our patient had idiopathic hypertrophic stenosis, multiple myeloma, and cardiac amyloidosis.

In our patient, we deemed it wise to avoid verapamil because of the repeated episodes of pulmonary edema. Current opinion is that if a patient has a history of pulmonary congestion or if the pulmonary artery wedge pressure is above 20 mm/Hg, verapamil should be used only if the other measures are not considered possible.[17]

This patient's terminal event was cardiogenic shock with congestive heart failure. When he was treated with conventional therapy for cardiogenic shock, he failed to improve. We speculate that recurrent pulmonary edema and death was due to the deleterious additive effect of both diseases on diastolic compliance.

Cardiac amyloid usually causes poor left ventricular systolic function. However, our patient had good left ventricular systolic function and could manifest an outflow gradient even while taking propranolol. Therefore, the diagnosis of a second infiltrative myopathy never was considered. Both hypertrophic cardiomyopathy and cardiac amyloid cause marked reduction in diastolic compliance.

We propose that the amyloidosis in the walls of multiple interstitial arteries and arterioles and the few interstitial deposits of amyloidosis, superimposed upon the marked reduction of left ventricular compliance of hypertrophic cardiomyopathy, led to the development of recurrent pulmonary edema and death.

The abnormal hemodynamics of each disease appeared to be complementary causing a fatal outcome.

REFERENCES

1. Teare RD: Asymmetrical hypertrophy of the heart. *Br Heart J* 20:1-18, 1958.

2. Perloff JK: Pathogenesis of hypertrophic cardiomyopathy: Hypotheses and speculations. *Am Heart J* 101:219-226, 1981.

3. Paredes JM, Mitchell BS: Multiple myeloma: Current concepts in diagnosis and management. *Med Clin North Am* 64:729-742, 1980.

4. Kyle RA, Bayrd ED: Amyloidosis: Review of 236 cases. *Medicine* 54:271-300, 1975.

5. St. John Sutton MG, Reichek N, Kastor JA, Giuliani ER: Computerized M-mode echocardiographic analysis of left ventricular dysfunction in cardiac amyloid. *Circulation* 66:790-799, 1982.

6. Carroll JD, Gaasch WH, McAdam KPWJ: Amyloid cardiomyopathy: Characterization by a distinctive voltage/mass relation. *Am J Cardiol* 49:9-13, 1982.

7. Wright JR, Calkins E: Clinical-pathological differentiation of common amyloid syndromes. *Medicine* 60:429-448, 1981.

8. Brooksby IAB, Jenkins BS, Coltart DJ, Webb-Peploe MM, Davies MJ: Left ventricular endomyocardial biopsy. *Lancet* 2:1222-1225, 1974.

9. Brooksby IAB, Coltart DJ, Webb-Peploe MM: Progress in endomyocardial biopsy. *Mod Concepts Cardiovasc Dis* 44:65-69, 1975.

10. Bharati S, Lev M, Denes P, Modlinger J, Wyndham C, Bauernfeind R, Greenblatt M, Rosen K: Infiltrativ cardiomyopathy with conduction disease and ventricular ar rhythmia: Electrophysiologic and pathologic correlations. *An J Cardiol* 45:163-173, 1980.

11. Cohen LS, Baunwald E: Amelioration of angina pec toris in idiopathic hypertrophic subaortic stenosis with beta adrenergic blockade. *Circulation* 35:847-851, 1967.

12. Rosing DR, Kent KM, Borer JS, Seides SF, Maron B Epstein SE: Verapamil therapy: A new approach to the pha macologic treatment of hypertrophic cardiomyopathy: Hemodynamic effects. *Circulation* 60:1201-1207, 1979.

13. Kaltenbach M, Hopf R, Kober G, Bussman WD, Kelle M, Peterson Y: Treatment of hypertrophic obstructiv cardiomyopathy with verapamil. *Br Heart J* 42:35-42, 197

14. Rosing DR, Kent KM, Maron BJ, Epstein SE: Verapam therapy: A new approach to the pharmacologic treatment hypertrophic cardiomyopathy. II. Effects on exercise capacit and symptomatic status. *Circulation* 60:1208-1213, 1979.

15. Rosing DR, Condit J, Maron GJ, Kent KM, Leon MC Banow RO, Lipson LC, Epstein SE: Verapmil therapy: A ne approach to the pharmacologic treatment of hypertrophi cardiomyopathy. *Am J Cardiol* 48:545-553, 1981.

16. Epstein SE, Rosing DR. Verapamil: Its potential fo causing serious complications in patients with hypertrophi cardiomyopathy. *Circulation* 64:437-441, 1981.

Medical Society of New Jersey Sponsors I.C. System Debt Collection Service

A PROFESSIONAL SYSTEM
Strong-arm tactics can backfire in this age of consumerism. This psychological approach maintains goodwill while introducing the debtor to pay you.

A REPUTABLE SYSTEM
I.C. System fully complies with the Federal Fair Debt Collection Practices Act, and with state consumer protection laws in force throughout the country. As the law varies, so do the methods.

A SAFE SYSTEM
A Hold Harmless indemnity agreement protects you from any legal entanglement resulting from the company's efforts to collect.

A NATIONAL ORGANIZATION
There are divisions for 48 states. If the debtor moves, he hears from his state division — at no extra charge to you. There is no need to rely on forwarding accounts to other agencies. Localization increases collection effectiveness.

IT'S EASY
Just turn in the debtor's name, address, phone number, type of account and amount owing. I.C. takes it from there.

PERSISTENCY PAYS
The company works every account for at least six months, or until the account is settled. Persistency collects.

A COMPREHENSIVE SYSTEM
All accounts — large or as small as $15, any age or location — are vigorously pursued. Such efforts produce more net profit for you.

IT'S INEXPENSIVE
Rates generally run 30% to 40% less than you find elsewhere. A big savings over other systems.

KEEPING YOU INFORMED
You get confidential activity reports showing the status of every account being serviced.

MSNJ SUPERVISION
The Society receives regular reports on the activity of I.C. System and is available to mediate any disputes.

FREE CUSTOMER HOT LINE
If you have a question, use the WATS line to contact your I.C. Customer Service Representative. Each one is especially trained to handle all types of problems and can give you the information you need within seconds.

BEST OF ALL, AN EFFECTIVE SYSTEM
Improved technology and experience have increased collections nearly tenfold over the past ten years. The company recovers more than four million dollars per month for customers. The job gets done for you. That's why I.C. System says with pride . . . THE SYSTEM WORKS.

To learn more about the I.C. Collection Service return this reply card today.

Medical Society of New Jersey
Two Princess Road
Lawrenceville, New Jersey 08648
#6801

TELL ME MORE about this highly effective collection service.

Name_____

Address_____

City_____ State_____ Zip_____

Signed_____ Title_____

Form # 3303

EFFECTIVE COLLECTORS PROVIDE FINANCIAL ADVICE

They are counselors, financial advisors, and often, understanding friends. They are cursed at, lied to, and thanked. They are I.C. System's telephone collectors. If the image you have of a collector is a burly six-foot hulk, then you are in for a surprise. Perci Berry is no hulk. Yet this five-foot three-inch woman has collected thousands of dollars for clients of I.C. System. "We distinguish ourselves from the strong-arm impression of collection agencies of years past," she said in a recent interview. "We take pride in our effective technique of collections." The technique, Perci explains, involves becoming a counselor to a debtor, working together to resolve a financial problem. "We say to debtors, 'We need your help.' Then we don't become their creditor's strong-arm, so to speak, we become the person who is going to help them clear up a problem," she said. "We are counselors." As counselors, Perci and her co-workers provide debtors with financial advice. After two years as a collector, Julia Denault has learned that many times people have assets they are not even aware of that they can borrow against. "We make these suggestions and provide ideas to help debtors through their financial troubles," Julia said. Often times, collector Kim Stevens finds debtors are not looking at their priorities. "They put a bill aside because it has been outstanding for so long they feel it can go a little longer," Kim said. "Or they feel since it's not the car or mortgage payment, can wait." She added, "We point out to them that it important." "I stress to debtors that they have a mo obligation to pay," Kim continued. "I tell them t person trusted you by extending credit, now you hav moral obligation to help him out." In some cases t collectors find a debtor is simply not able to pay, "K said, "I try to set up a payment plan that will not invol serious hardship to him, but will get the debt clear up." Many times an unpaid bill is traced back to dispute over the purchased goods or service. Julia e plained that although the dispute may have some me the debtor must do more than just ignore the bill. "C tomers have an obligation to register a dispute — to back and seek satisfaction," she said. "Take the prod back. Go back to where you bought it and tell th what's wrong." As an experienced collector, Julia fe it is important to give the creditor an opportunity to ma a satisfactory settlement. "Most creditors, most bus esses we work with, are very conscientious about satis ing complaints,whether it's a partial refund or doing t work over again," Julia said. Working together, t collector and debtor can resolve a dispute, negoti payments or discuss a solution to a financial problem. this role, telephone collectors have proven to perform important function in the recovery of accounts for clie of I.C. System.



NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST CLASS PERMIT NO. 4990 ST. PAUL, MN.

POSTAGE WILL BE PAID BY ADDRESSEE

I.C. SYSTEM, INC.

444 East Highway 96
P. O. Box 64639
St. Paul, Minnesota 55164



THE SMOKING CESSATION REDUCTION ACTION PROGRAM

NORMAN HYMOWITZ, PH.D., IDAMARIE LAQUATRA, SARAH KARL, NEWARK*

Programs to help adults stop smoking have been frustrated by high rates of relapse. Long-term clinical trials for disease prevention yield better abstinence rates. SCRAP, a worksite-based program, will determine whether effective features from clinical trials can be implemented to produce comparable abstinence rates.

The issues of cigarette smoking and its modification pose important challenges to professionals in public health and behavioral medicine. The 1979 report of the Surgeon General documents the significant health hazards of cigarette smoking.[1] Despite the vast array of health statistics contained in the report, millions of adults continue to smoke and young people are acquiring the smoking habit at an alarming rate.[2] While antismoking activities have contributed to a decline in adult smoking rates[3] and a decrease in the per capita consumption of cigarettes,[4] behavioral intervention programs specifically designed to help adults stop smoking have met with limited success. Many stop-smoking programs yield comparable satisfactory end-of-treatment quit-rates (i.e. 40 to 60 percent), but few have succeeded in maintaining nonsmoking behavior over time.[5-8] Hunt and Bespalec reported that 70 to 80 percent of successful graduates of stop-smoking programs relapse within one year following the end of treatment.[9] While aversive techniques tend to produce somewhat better quit-rates,[10] relapse remains a problem,[11] and their utility from a public health viewpoint is limited by potentially serious adverse side effects.[12]

Findings from recently completed prospective clinical trials for the prevention of heart disease yield long-term quit-rates which exceed those typically reported in the smoking modification literature.[13-16] After six years of followup in the Multiple Risk Factor Intervention Trial (MRFIT), for example, close to 50 percent of the Special Intervention (SI) group who reported smoking at the start of the trial reported not smoking[13] and 56 percent of SI participants who quit smoking by the end of the initial ten-week group intervention program never relapsed through the first four years of the trial (data for six years of followup for this cohort are not yet available).[17] The reported quit-rate after five years of the Oslo Study was 30 percent;[14] for the intensive intervention group in the Stanford program, 50 percent after three years;[15] and for the Randomized Trial of Antismoking Advice in London, 55 percent after nine years of followup.[16]

Prospective clinical intervention trials differ in many ways from more traditional stop-smoking programs, which make it difficult to determine which features of the trials account for the higher long-term abstinence rates. The focus of clinical trials is on disease prevention, and cigarette smoking often is one of several risk factors treated. Thus, it is likely that participants in clinical trials are better able to personalize the risk which smoking presents, to be more aware of the potential benefits of stopping smoking, and to ap-

*From UMDNJ-New Jersey Medical School, Department of Psychiatry and Mental Health Science. Correspondence may be addressed to Dr. Hymowitz, UMDNJ-New Jersey Medical School, 100 Bergen Street, Newark, NJ 07103.

preciate better the concepts of disease prevention and health enhancement than smokers enrolled in more traditional stop-smoking programs.

Participants in clinical trials usually undergo extensive medical screening and evaluation at the start and during the course of the trial. It is conceivable that the periodic followup and medical assessment contribute to an overall milieu in which the effectiveness and long-term impact of behavioral stop-smoking techniques are enhanced. The reactive impact of periodic health assessment alone on smoking cessation may be seen best by the performance of participants assigned to control conditions in the clinical trials. They are examined periodically but usually do not receive advice and assistance in discontinuance of smoking. In the MRFIT, the Usual Care Group quit-rate increased each year, yielding a quit-rate at year six of 29 percent. The quit-rate for the control group in the Oslo Study increased to 18 percent at year five.[14] In the Paris Cardiovascular Risk Factor Trial, the quit-rate for controls at year two was 28 percent,[18] and for the control group in the Multifactoral Prevention Trial in Gothenburg, Sweden, it was 26 percent after four years.[19] These rates reflect the impact of consistent followup and periodic medical evaluation.

Smaller studies which used the features of long-term followup and medical evaluation showed long-term nonsmoking rates comparable to the clinical trials. Hymowitz, Lasser, and Safirstein studied the effects on smoking cessation of a filter system for gradual smoking withdrawal.[20] This study emphasized the health benefits of smoking cessation and required participants to return to the clinical center periodically for measurement of carbon monoxide, pulmonary symptoms, pulmonary function, serum cholesterol, and blood pressure. Subjects were assigned randomly to one of three experimental conditions: quit smoking on their own, quit smoking through the use of a placebo filter system, or quit smoking through the use of the real filters. No other form of assistance to cease smoking or to remain abstinent was used. The initial quit-rate at the end of eight weeks was modest, with no differences among conditions. However, more than 50 percent of the initial quitters still were abstinent one year later. This finding is consistent with clinical trial data in suggesting that emphasis on health enhancement, feedback about health status, and persistent followup are important ingredients for long-term smoking cessation.

Recent studies by Malotte, Fielding and Danaher[21] and Tongas[22] also demonstrate the importance of emphasis on health enhancement and intensive followup in more traditional undertakings. Malotte et al. described the results of the smoking cessation component of a 24-day residential program aimed at achieving lasting improvement in known risk factors for heart and lung disease. Data on self-reported abstinence revealed 72 percent of the smokers were abstinent at discharge and 53 percent were abstinent at six months. In one group, Tongas employed a 5-day treatment program of aversive conditioning and covert conditioning in combinations with intensive followup and maintenance over a 12-month period. Self-reports of abstinence for subjects who completed the 5-day program in the combined treatment group revealed 77 percent abstinence at 6 months, 77 percent at 2 months, and 62 percent abstinence at 24 months

Smoking cessation and long-term abstinence a complex processes which are influenced by a vari of factors. Psychosocial variables which predispose abstinence and relapse, the effectiveness of differ modes of therapy, and patients most likely to pr from a particular approach are important topics future research. The clinical trial data suggest int vention strategies prove more effective when coup with an overall health milieu and long-term follow

It is of utmost importance to determine whet variables which played an important role in produc long-term cessation results in the clinical trials can incorporated in a cost-effective manner in other s tings to enhance the impact of more traditional st smoking programs. While resources available clinical trials are not typically available in other s tings, it is possible to approximate the clinical t atmosphere in a systematic fashion. For exam smokers may be informed that they are taking part a long-term health enhancement and intervention fort from the start, so that maintenance and follow become integral features of the program. Modif physical examination and periodic assessment may included to help smokers personalize their risk smoking and remain aware of the health benefits stopping. Such examinations should include medi and pulmonary history to identify "high-risk smoke and, where possible, the measurement of carbon m oxide, coronary risk factors, and spirometry. Coope tive arrangements with community health agencies area hospitals would enable a wide variety of smoki cessation programs to incorporate health assessme health enhancement, and regularly scheduled follow visits. Based on the clinical trial data, such featu may be expected to enhance the impact of interventi and help create an environment conducive to lo term maintenance of nonsmoking behavior.

Where possible, health professionals should enl the support of the family, the community, and t personnel at the worksite to enhance long-term sm ing modification. Interventions at the worksite are a vantageous because they afford opportunities for f lowup.[24] Many communities have events related to f ness and health, such as stress management class at adult schools, weight loss and low calorie cooki classes, and various health fairs and exhibits. bringing various activities to the attention of the me bers of smoking groups, incorporating attendance these events into specific behavioral contracts, a providing followup at the worksite and elsewhere, may be possible to carry out a systematic and co prehensive smoking cessation and followup progra which leads to high rates of initial cessation as w as successful long-term abstinence. One should n that in the Stanford Heart Disease Prevention P gram, the most success in smoking cessation was those who received mass media health education co munications, face-to-face group intervention, and s tematic followup.

SCRAP

A smoking cessation program currently underway the New Jersey Medical School, the Smoking Cess

)n Reduction Action Program (SCRAP), is specifically signed to determine whether features which oduced high long-term cessation rates in clinical ials for disease prevention can be applied in a community setting in a cost-effective manner to produce mparable satisfactory long-term rates of smoking ssation. Key features which the program borrows)m clinical trials are: (a) commitment of participants a long-term evaluation of the health impact of garette smoking and health benefits of cessation as)posed to enrollment in a short-term stop-smoking)gram; (b) initial assessment of cardiovascular risk ctors, pulmonary function, carbon monoxide ex)sure, and medical history to help smokers per)nalize the health risks which cigarettes present; (c) riodic evaluation of changes in these measures for ie year to document the health benefits which accrue hen smokers stop smoking; (d) skills to stop smoking id to remain abstinent; and (e) health education and ganizational management activities through which nokers may be more likely to initiate and maintain alth-related behaviors. (The latter health education tivities derive from the successful experience of the anford Three Communities Program.)

The features described are incorporated in SCRAP rough three interacting components: (a) organizanal management (i.e. development of nonsmoking licies at the worksite); (b) health education (i.e. diovisual presentations, brochures, self-help stop)oking aids); and (c) an intensive group intervention d followup program. The organizational manage-nt and health education components create an erall milieu at the worksite within which smoking ssation and long-term nonsmoking maintenance are ilitated. The intensive group intervention and folvup program incorporates the most advanced con)t in stop-smoking technology and specifically is de;ned to help adult smokers stop smoking and remain garette free.

To maximize the opportunity for followup and intention, the SCRAP will be carried out at a worksite tting. For the initial pilot project, seven hospitals in idson, Essex, and Union Counties have been ected: Bayonne Hospital, Elizabeth General Hospital, Elizabeth Hospital, Alexian Brothers Hospital, Newk Beth Israel Hospital, East Orange General Hospital, d St. Mary's Hospital, Orange. Representatives of the spitals were trained to carry out all components of CRAP. Each smoking counselor conducts three)oking groups; one each in the fall, winter, and ring. All participants will be followed for one year lowing the end of initial group intervention, so it is pected that the pilot phase of SCRAP will be com-ted in the spring of 1985.

The pilot phase of SCRAP will lead to the develop-nt of a manual for training smoking counselors, a anual for conducting initial group intervention and lowup, and a manual for health education and or-nizational management (e.g. no-smoking policies, inges for nonsmokers, reduced insurance premiums nonsmokers). The Metropolitan Chapter of the nerican Heart Association, which is sponsoring CRAP, eventually will serve as a certifying agency for CRAP smoking counselors; SCRAP manuals and ma-ials will be available to the public for implementation in other settings under Heart Association supervision.

EVALUATION

Evaluation of the effectiveness of SCRAP will be accomplished through several means. While all hospitals will implement the SCRAP initial group intervention and followup program, only three randomly selected hospitals will implement the health education and organizational management components. Thus, it will be possible to assess the effects of the health education and organizational management component on initial and long-term cessation by comparing changes in smoking rates among SCRAP participants in the seven hospitals. We expect that the hospitals receiving group intervention plus health education and organizational management will yield superior long-term (12 months) quit-rates than the hospitals receiving only the group intervention program. Carbon monoxide measurements will serve as objective measures of smoking status.[23]

Two smoking surveys will be conducted among employees at the seven hospitals. This will permit assessment of smoking habits for each employee group in the hospitals at the start and end of the program. We anticipate that there will be significantly more cessation and changes in smoking behavior among employees not taking part in the SCRAP group intervention program in the hospitals receiving the health education and organizational management components of SCRAP than in the hospitals not receiving this aspect of the program.

Seventy to 80 percent of successful graduates of stop-smoking programs relapse within one year following the end of treatment.

Another form of evaluation will be based on feedback from the newly trained SCRAP smoking counselors. The SCRAP group intervention manual, for example, contains evaluation forms to be completed after each of the eight weekly group sessions. Smoking counselors will be asked to comment on the flow and content of the sessions, time constraints, and handouts and audiovisual materials. They also will be asked to describe any modification they had to make when conducting the sessions. Based on their input, the manual and program will be revised. By the spring of 1985, it will be possible to evaluate the effects of SCRAP on the smoking behavior of hospital employees, the specific influence of health education and organizational management, and the utility of SCRAP materials and manuals. At that point, a decision will be made concerning the availability of SCRAP for implementation by other hospitals and worksites.

SUMMARY

Cigarette smoking represents a major threat to public health, increasing risk of premature heart attack,

cancer, and noncancerous bronchopulmonary disease. Efforts to help smokers stop smoking continue, with considerable attention being directed at ways of achieving long-term abstinence. SCRAP borrows heavily from the design and organization of long-term clinical trials for disease prevention whose long-term cessation rates were among the best reported to date. Whether or not it is possible to produce similar results in community and worksite settings, at far less cost, remains an important empirical question. However, in view of the growing numbers of young people who smoke, as well as the increasing number of women smokers, the need to explore new ways to intervene on adult smoking behavior cannot be overemphasized. SCRAP is a multicomponent program, featuring contemporary behavioral approaches to smoking cessation and long-term abstinence, health education, and organizational management. It seeks to encourage cessation and promote abstinence through creation of an overall milieu in which the effectiveness of smoking cessation strategies are enhanced. To the extent that SCRAP is successful in demonstrating methods for achieving long-term abstinence, the program will serve the important role of bridging research, clinical trial technologies, and community applications. It is hoped that SCRAP will provide insight and guidance into how principles and methods derived from a variety of approaches can be pooled and synthesized to yield more successful interventions.

ACKNOWLEDGEMENTS

This work was supported in part from grants from the Metropolitan Chapter of the American Heart Association, Demonstration and Education Research Grant R18HL 28910 (NIH) and postdoctoral training grant, Behavioral Aspects of CHD Prevention T-32-HL-07454-01A26 (NIH).

The Directors of SCRAP for each of the hospitals are as follows: East Orange General Hospital, Ms. Mary Jane Guensch; St. Mary's Hospital, Ms. Regina Coyle; Bayonne Hospital, Mr. Fred Lang; Alexian Brothers Hospital, Ms. Susan Felski-Hessel and Ms. Ann Goldberg; Elizabeth General Hospital, Mr. Steve Kendall; Newark Beth Israel Hospital, Ms. Renee Salkin; St. Elizabeth Hospital, Mr. Michael O'Hea and Mr. Paul Chabella.

REFERENCES

1. U.S. Public Health Service: Smoking and health: A report to the surgeon general. DHEW Publication No. (PHS) 79-50066. Washington, D.C., U.S. Government Printing Office, 1979.

2. Hymowitz N: Teenage smoking: A medical responsibility. *Developmental Behavioral Pediatrics* 1:164-172, 1980.

3. Schuman LM: Patterns of smoking behavior, in Jarvik ME, Gritz JW, Vogt TM, West LJ (eds), *Research on Smoking Behavior*. NIDA Research Monograph Series 17. DHE Publication No. (ADM) 78-581, 1977.

4. Warner KE: Cigarette smoking in the 1970s: The impa of the antismoking campaign on consumption. *Scier* 211:729-731, 1981.

5. Benfari RC, Ockene JK, McIntyre KM: Control of cigar te smoking from a psychological perspective. *Annu Rev Pub Health* 3:101-128, 1982.

6. Leventhal H, Cleary PP: The smoking problem: A revi of the research and theory in behavioral risk modificati *Psychological Bulletin* 88:370-405, 1980.

7. Lichtenstein E: The smoking problem: A behavioral p spective. *J Consult Clin Psychol* 50:804-819, 1982.

8. Vogt TM: Cigarette smoking: History, risks, and behav change. *Int J Mental Health* 11:6-43, 1982.

9. Hunt WA, Bespalec DA: An evaluation of curre methods of modifying smoking behavior. *J Clin Psych* 30:431-438, 1974.

10. Danaher BM: Research on rapid smoking: Inter summary and recommedations. *Addictive Behavi* 2:151-166, 1977.

11. Raw M, Russell MAH: Rapid smoking, cue exposu and support in the modification of smoking. *Behavior F search Therapy* 18:362-373, 1980.

12. Hymowitz N: Behavioral approaches to preventi heart disease: Risk factor modification. *Int J Mental Hea* 9:27-69, 1980.

13. Multiple Risk Factor Intervention Trial Group and M tiple Risk Factor Intervention Trial: Risk factor changes a mortality results. *JAMA* 248:1465-1477, 1982.

14. Hjermann I, Holme I, Velve Byre K, Leren P: Effect diet and smoking intervention of the incidence of corona heart disease. *Lancet* 11:1303-1310, 1981.

15. Meyer AJ, Nash JD, McAlister AL, Maccoby N, Farquh JW: Skills training in a cardiovascular health education ca paign. *J Consult Clin Psychol* 48:129-142, 1980.

16. Rose G, Hamilton PJS, Calwell L, Shipley MJ: A ra domized controlled trial of anti-smoking advice: 10-year sults. *J Epidemiol Community Health* 36:102-108, 1982

17. Hughes GH, Hymowitz N, Ockene JK, Simon N, Vo TM: The Multiple Risk Factor Intervention Trial (MRFIT). Intervention on smoking. *Prev Med* 10:476-500, 1981.

18. Cambien F, Richard JL, Ducimetiere P, Warnet J Kahn J: The Paris Cardiovascular Risk Factor Preventi Trial. *J Epidemiol Community Health* 35:91-97, 1981.

19. Werko L: Prevention of heart attacks: Multifactorial pr ventive trial in Gothenburg, Sweden. *Ann Clin Res* 11:71-7 1979.

20. Hymowitz N, Lasser NL, Saferstein BH: Effects of grad ated external filters on smoking cessation. *Prev M* 11:85-95, 1982.

21. Malotte CK, Fielding JE, Danaher BG: Description an evaluation of the smoking cessation component of a multip risk factor intervention program. *Am J Public Heal* 71:844-847, 1981.

22. Tongas PN: The long-term maintenance of nonsmoki behavior, in Jarvik ME, Cullen JW, Gritz ER, Vogt TM, We LJ (eds), *Research on Smoking Behavior*. NIDA Resear Mongraph Series 17. DHEW Publication No. (ADM) 78-5 1977.

23. Hymowitz N: Personalizing the risk of cigarette smo ing. *J Med Soc NJ* 77:579-582, 1980.

24. Orleans CS, Shipley RH: Worksite smoking cessati initiatives: Review and recommendations. *Addictive Beha iors* 7:1-16, 1982.

BROWN **THE BROWN PHARMACEUTICAL CO., INC.**

2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

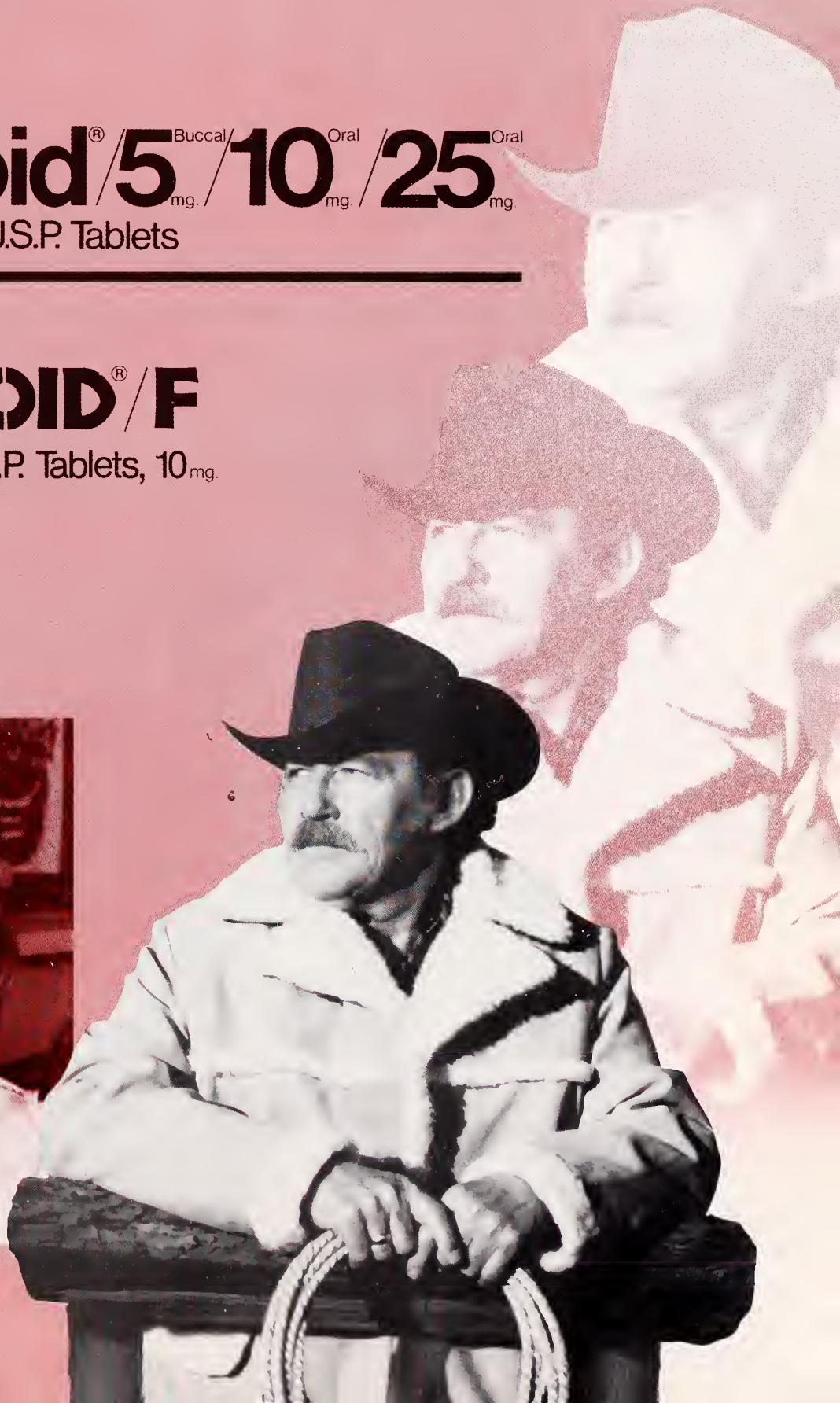
Android®/5 mg. Buccal/10 mg. Oral/25 mg. Oral

Methyltestosterone U.S.P. Tablets

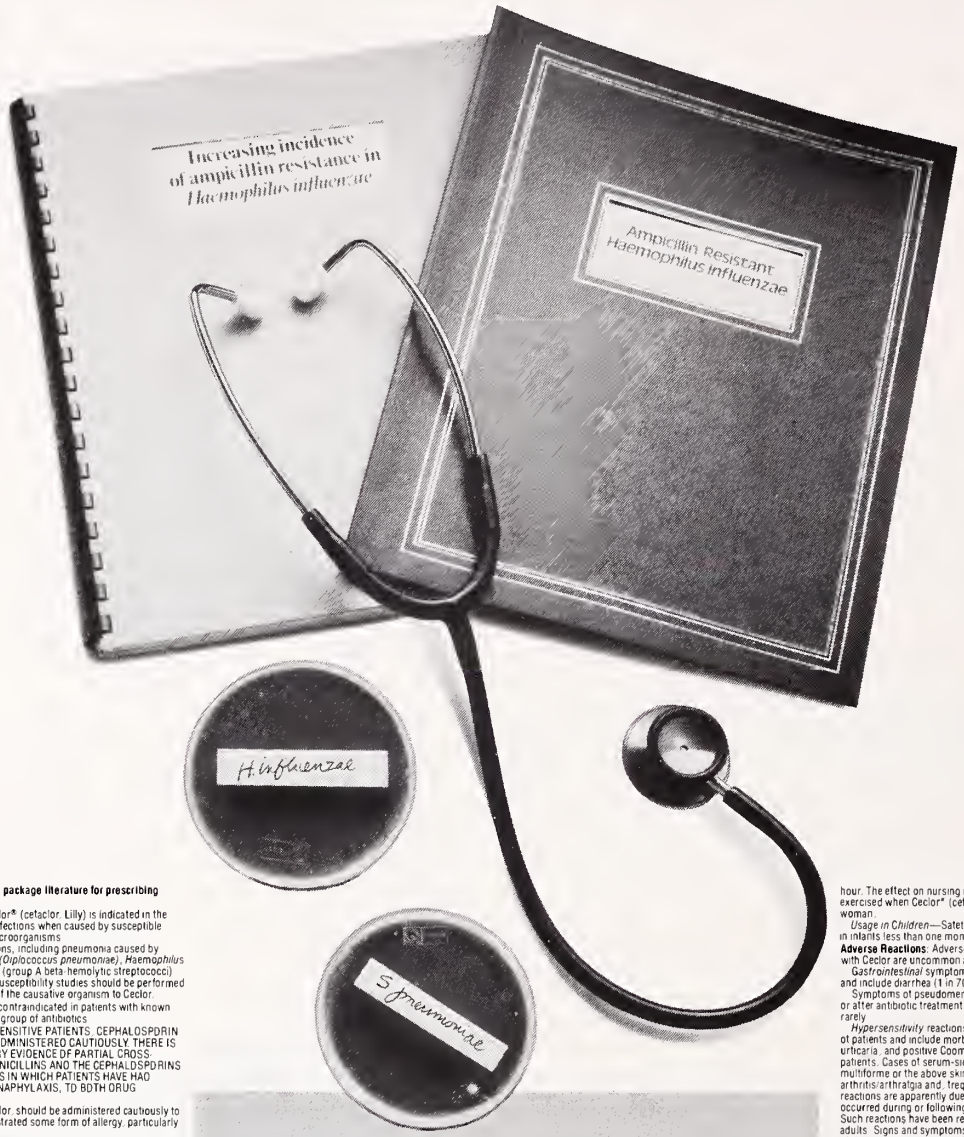
ANDROID®/F

Fluoxymesterone U.S.P. Tablets, 10 mg.





An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor
Pulvules®, 250 and 500 mg

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.*

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., *8*: 91, 1975.
2. Antimicrob. Agents Chemother., *11*: 470, 1977.
3. Antimicrob. Agents Chemother., *13*: 584, 1978.
4. Antimicrob. Agents Chemother., *12*: 490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II-880, Washington, D.C., American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., *13*: 861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487, New York, John Wiley & Sons, 1979.

© 1982, ELI LILLY AND COMPANY

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

Lilly

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

300035

Promoting Compliance in Hypertensive Patients

Phyllis Supino, ed.d., Audrey R. Gotsch, ph.d., David Van Harlingen, ed.d., Judy Hebble, piscataway*

A survey was conducted to obtain information about strategies used by New Jersey private practitioners to promote compliance in hypertensive patients. Findings revealed that while patient noncompliance was of universal concern, attempts to counter it were limited, variable, and related to physician profile characteristics.

The control of hypertension has received significant attention in the literature due to the pervasive nature of this disease entity, its potentially life-threatening nature, and the difficulties associated with treatment. Although research has demonstrated that medication can reduce blood pressure and the concomitant incidence of coronary artery disease and chronic renal failure,[1] the effective management of hypertension often is compromised by patient nonadherence to the prescribed treatment regimen and the practitioner's understanding of this phenomenon.[2-4] The problem of noncompliance for hypertensive patients arises for three major reasons: the asymptomatic nature of this condition, the prolonged treatment period, and the potentially adverse effects of medications.[5]

A recent study by Haynes, Mattson, and Engelbretson reported that health care professionals have been using a variety of strategies in different delivery settings which have the potential to promote compliance and allow for more patient involvement and responsibility in long-term therapy maintenance.[6] However, these authors identified a gap in the available information regarding the private practitioners' preparation for and efforts to address this problem which, they concluded, might be due to the low incidence of formal reporting by this group. Recognizing the need for such data from private physicians, the Office of Consumer Health Education, Department of Environmental and Community Medicine, UMDNJ-Rutgers Medical School, surveyed private practice physicians in New Jersey.

Hypertension was chosen as the subject of the study because it ranks among the conditions for which compliance problems are most critical. The purposes of the survey were: (a) to determine for this population the nature and extent of previous educational preparation in the broad area of patient management techniques, (b) to evaluate the nature and scope of strategies used by these physicians to promote medication compliance in hypertensive patients, and (c) to assess the relationship between physician profile characteristics and use of compliance-promoting strategies.

METHODOLOGY

During the spring of 1981, the UMDNJ-Office of Consumer Health Education developed and mailed survey forms to a random sample (n=1,309) of New Jersey private practice physicians, representing the primary care specialties of internal medicine, general practice, and family practice. The form consisted of two sections containing predominately closed-ended, multiple-

*From the Office of Consumer Health Education, UMDNJ-Rutgers Medical School. Correspondence may be addressed to Dr. Supino, UMDNJ-Rutgers Medical School, University Heights, Piscataway, NJ 08854.

TABLE 1

Percentage of Respondents Using Compliance-Promoting Strategies Differing Significantly on a Chi-Square Test By Age, Date of Graduation, and/or Number of Years in Present Practice

Strategy	Age					
	Under 36	36-47	48-57	58-67	Over 67	χ^2 (df=4)
Telephone reminders	—	—	—	—	—	—
Mail reminders	39	24	6	11	8	16.75†
Self-monitoring	—	—	—	—	—	—
Nonphysician counseling	44	44	24	9	10	19.59†

Strategy	Medical School Graduation Date						Number of Years in Present Practice					
	Pre-1940	1940-1949	1950-1959	1960-1969	1970-1979	χ^2 (df=4)	Under 10	10-19	20-29	30-39	Over 40	χ^2 (df=4)
Telephone reminders	29	25	30	27	55	10.17*	—	—	—	—	—	—
Mail reminders	7	13	10	26	34	12.07*	30	20	7	13	5	10.95*
Self-monitoring	42	52	57	84	71	12.24*	75	71	52	54	38	10.87*
Nonphysician counseling	4	13	26	40	49	20.42†	42	35	27	11	6	14.60†

*$P<.05$
†$P<.01$
Note: Data for nonsignificant differences have been omitted.

choice items. The first section, "General Information," collected data on selected demographic characteristics of the respondents, characteristics of their medical education, nature of current practice and specialty area, and amount of time spent with patients during an average office visit. The second section, "Hypertensives and Compliance Strategies," contained questions that measured the percent of patients being treated for a hypertensive condition, perceived levels of compliance among these hypertensive patients, and attitudes toward the noncompliant patient. In addition, this section assessed the nature of organizational, behavioral, and educational strategies used to foster compliance.

RESULTS

Two hundred sixty-three physicians responded; of these, 209 (79.5 percent) returned completed forms within the given time period and their responses form the basis of this report. All data were analyzed to determine the frequency of responses to each of the various questions on the survey form and all frequencies were converted to percentages of the total response for that item. Chi-square tests were conducted to determine the relationship between respondent profile characteristics and implementation of individual compliance strategies. In addition, analysis of variance was used to examine the effects of these profile characteristics on the number of compliance strategies reported.

Because followup of nonrespondents was not possible within the design and budget constraints of this study, representativeness of response reported by the population surveyed was examined through co parisons with data obtained from respondents w had returned completed survey forms between two a ten months late (n=54). This technique, described the literature as an alternative to traditional follow strategies,[7] is predicated upon findings of similarity response between very late responders and nonrespo dents. These comparisons revealed no significant d ferences between early and late respondents on a profile characteristic except that the latter group r ported more training during residency in int personal skills (χ^2=5.48, df=1, $P<.05$), patient educ tion (χ^2=5.51, df=1, $P<.05$), and patient tracki procedures (χ^2=4.33, df=1, $P<.05$). No other educ tional differences were found between the two grou of respondents. Moreover, both early and late respo dents were similar with respect to number of sche uled office hours, time spent per patient visit, numb of hypertensive patients seen, techniques used assess noncompliance, and attitudes toward and b haviors directed at noncompliant patients (includi the nature of compliance-promoting strategies use

Respondents predominantly were male (95 percer and ranged from 27 to 81 years of age with a medi age of 52 years. Twenty-one percent graduated fro medical school prior to 1940, 19 percent in the 194 22 percent in the 1950s, 14 percent in the 1960s, a 24 percent in the 1970s. The distribution of numb of years in practice was consistent with the date graduation. Of those responding, 7 percent receiv their medical degrees from New Jersey schools, 68 p cent from states other than New Jersey, and the r maining 25 percent from foreign medical schools. T

ajority of respondents indicated they had been ained in interpersonal skills, patient education techques, or patient tracking/monitoring procedures, t most instruction occurred after medical school. fty-three percent of the sample indicated that their rrent specialty area was general or family practice, d 47 percent specialized in internal medicine; approximately 10 percent reported expertise in more an one specialty. Sixty-eight percent of the respondents maintained a solo practice, 10 percent were enged in a partnership, and 10 percent were involved a group practice. Twelve percent were either residents, administrators, or researchers and were not included in further analyses so that the data would reflect only the attitudes and behaviors of private practice physicians directly involved in patient treatment. The median number of office hours scheduled per eek was 28 and the time spent per patient visit was proximately 16 minutes. The number of patients ing treated for hypertension varied widely among spondents with the typical physician treating approximately 16 percent of patients for this condition. he techniques used to assess regimen compliance by e physicians included (in order of descending use): ood pressure checks, patient self-reports, diet reorts, pill counts, reports of exercise activities, reports salt level intake, consultation with the pharmacist, d serum drug monitoring. The most frequently used chniques were blood pressure checks and patient lf-reports (89 and 75 percent of the sample, respectely), although most respondents reported the use of ultiple techniques.

Respondents varied in their estimates on the percentage of time patients complied with instructions in rious areas. Respondents estimated greatest compiance for appointment-keeping and pill-taking and ast compliance for diet, exercise, and self-monitoring. he percentage unable to estimate compliance rates nged from 1 percent for appointment-keeping to 19 rcent for self-monitoring.

Although 97 percent of the respondents thought at the physician should have primary responsibility r counseling the noncompliant patient, as many as percent, when confronted with noncompliant paents, reported feelings of frustration. Other reactions ere ambivalence, anger, sense of failure, resignation, mpathy, and challenge.

The distribution of behavioral responses to patient oncompliance was essentially bimodal, i.e. 63 percent all respondents reported that they would attempt to termine the cause of noncompliance and 47 percent dicated they would admonish the patient. Very few spondents indicated they would suggest another ysician, refer the patient to a specialist, or take no tion.

The strategy most commonly employed to promote mpliance in hypertensive patients was individual unseling by the physician (84 percent of the sample). her educational strategies less frequently used were dividual counseling by a nonphysician (22 percent), ogrammed instruction (19 percent), and small and ge group instruction (6 and 5 percent, respectively). The most widely used behavioral strategies (75 to 79 rcent of the sample) were tailoring the treatment to dividual needs, reinforcement through praise, and family involvement. Approximately half of the respondents also reported use of graduated treatment regimens and self-monitoring for this purpose. The least commonly used behavioral strategies were support groups (14 percent) followed by reinforcement through contracts and incentives (28 percent).

The practice of scheduling individual rather than block appointments and reducing the waiting time to see the physician were the organizational strategies most widely used to promote compliance in this patient population (62 and 44 percent of the sample, respectively). Phone call reminders also were used by 27 percent of the respondents for this purpose. Other organizational strategies (i.e. special referral clerks, mail reminders, checking with the pharmacist, and home visits) were used by only 11 to 18 percent of this group.

One of the objectives of the study was to determine whether the physician's use of specific compliance-promoting strategies was related to specific profile characteristics. To examine this question, respondents were categorized according to the following variables: age (under 36, 36 to 48, 49 to 57, 58 to 67, and over 67), date of graduation from medical school (pre-1940s, 1940 to 1949, 1950 to 1959, 1960 to 1969, 1970 to present), and number of years in present practice (less than 10, 10 to 19, 20 to 29, 30 to 39, and more than 40). The categories within each variable then were compared through chi-square tests on utilization of various strategies. The results of these analyses (Table 1) revealed a number of significant relationships, i.e. younger physicians were more likely than older physicians to use mail reminders to facilitate compliance ($\chi^2 = 16.75$, df=4, $P<.01$) and to allow nonphysicians to participate in patient counseling ($\chi^2 = 19.59$, df=4, $P<.001$). Consistent with the above, recent graduates from medical school were more likely than earlier graduates to employ the above strategies ($\chi^2 = 12.07$, df=4, $P<.05$ and $\chi^2 = 20.42$, df=4, $P<.001$, respectively) as well as to use phone reminders ($\chi^2 = 10.17$, df=4, $P<.05$) and self-monitoring techniques ($\chi^2 = 12.24$, df=4, $P<.05$) to increase compliance. Similarly, the number of years in practice was inversely related to use of mail reminders ($\chi^2 = 10.96$, df=4, $P<.05$), patient self-monitoring techniques ($\chi^2 = 10.87$, df=4, $P<.05$), and nonphysician counseling ($\chi^2 = 14.60$, df=4, $P<.01$). In addition, physicians with newer practices were more likely than physicians with more established practices to tailor treatment regimens to individual patient needs ($\chi^2 = 10.83$, df=4, $P<.05$).

The relationship between strategy usage and educational background also was evaluated. Respondents were compared on the basis of whether they received their medical education in domestic or foreign institutions. This analysis showed only one significant result, i.e. American-educated physicians were more likely than foreign-educated physicians to use individually scheduled appointments rather than block appointments ($\chi^2 = 9.20$, df=1, $P<.01$). Respondents also were compared on the basis of previous training in interpersonal skills, patient education techniques, and patient tracking/monitoring techniques by source of training (i.e. medical school, residency, or post-residency instruction). The results of these analyses

TABLE 2

Percentage of Respondents Using Compliance-Promoting Strategies Differing Significantly On a Chi-Square Test by Prior Training in Interpersonal Skills

Strategy Used	Source of Prior Training								
	Medical School			Residency			Postresidency		
	No	Yes	χ^2 (df=1)	No	Yes	χ^2 (df=1)	No	Yes	χ^2 (df=1)
Home visits	17	36	6.49*	15	33	5.55*	—	—	—
Reduced waiting time	—	—	—	—	—	—	47	69	5.49*
Pharmacist check	—	—	—	11	31	6.45*	—	—	—
Family support	—	—	—	—	—	—	77	92	5.46*
Support groups	—	—	—	13	30	5.12*	10	33	8.91*
Self-monitoring	52	75	7.24†	52	73	5.69*	—	—	—
Contractual agreements	—	—	—	29	52	6.76†	27	50	6.13*
Physician counseling	—	—	—	89	99	5.50*	86	99	7.88†
Programmed instruction	19	34	4.40*	16	37	7.49†	—	—	—

*$P<.05$
†$P<.01$
Note: Data for nonsignificant differences have been omitted.

TABLE 3

Percentage of Respondents Using Compliance-Promoting Strategies Differing Significantly On a Chi-Square Test by Prior Training in Patient Education

Strategy Used	Source of Prior Training								
	Medical School			Residency			Postresidency		
	No	Yes	χ^2 (df=1)	No	Yes	χ^2 (df=1)	No	Yes	χ^2 (df=1)
Home visits	18	37	6.07*	—	—	—	—	—	—
Referral clerks	12	25	3.86*	11	26	4.47*	—	—	—
Reduced waiting time	—	—	—	—	—	—	50	69	4.55*
Support groups	13	36	9.21†	12	33	8.21†	11	32	6.86†
Self-monitoring	52	80	9.04†	51	78	8.86†	—	—	—
Contractual agreements	29	57	9.73†	29	57	9.78†	—	—	—
Programmed instruction	18	39	6.78†	14	42	11.56†	13	31	5.26*

*$P<.05$
†$P<.01$
Note: Data for nonsignificant differences have been omitted.

(Tables 2, 3, and 4) suggest that training in any of the above patient management areas enhanced the use of compliance strategies (i.e. home visits, reduced waiting time, support groups, self-monitoring, contractual agreements, and programmed instruction) and the effects on other strategies varied as a function of the specific type of training. Various strategies also were affected differently as a function of source of training, with most effects attributable to training during residency.

The use of strategies also was compared to the number of office hours scheduled per week, the average time spent with patients, the percentage of hypertensive patients, and the time spent with these patients. No significant relationships were found.

The final analysis examined the number of compliance strategies used, by strategy type, and the extent to which these values were affected by profile characteristics. This analysis showed that the mean numb of organizational and educational strategies used l all respondents was 1.93 and 1.33, respectively, wher as the mean number of behavioral strategies used w 3.75. Table 5 shows the mean number of complian strategies reported within each strategy type, by profi variable, where significant differences were four through analysis of variance. These results general are consistent with those found for individu strategies; namely, the number of organizational ar behavioral (but not educational) strategies used we affected negatively by age* ($F=2.55$, df=4,204, $P<.0$ and $F=4.24$, df=4,204, $P<.05$, respectively) an

*While the mean number of strategies used showed a mon tonic relationship for age and related factors, posth analyses using Duncan's Multiple Range Tests failed to der onstrate sharp differences between adjacent age and ag related groupings.

TABLE 4

Percentage of Respondents Using Compliance-Promoting Strategies Differing Significantly On a Chi-Square Test by Prior Training in Patient Monitoring Techniques

Strategy Used	Source of Prior Training								
	Medical School			Residency			Postresidency		
	No	Yes	χ^2 (df=1)	No	Yes	χ^2 (df=1)	No	Yes	χ^2 (df=1)
Home visits	—	—	—	15	33	5.07*	—	—	—
Reduced waiting time	—	—	—	48	71	5.58*	—	—	—
Support groups	16	38	6.36*	14	33	5.50*	12	33	6.96†
Self-monitoring	55	84	7.06†	49	86	15.45†	—	—	—
Contractual agreements	33	58	5.51*	29	64	13.71†	—	—	—
Graduated regimens	—	—	—	—	—	—	71	88	4.86*
Programmed instruction	20	44	6.48*	18	40	6.66	15	31	3.95*

*$P<.05$
†$P<.01$
Note: Data for nonsignificant differences have been omitted.

TABLE 5

Mean Number of Organizational, Behavioral, and Educational Strategies Used Differing Significantly on an Analysis of Variance by Selected Profile Characteristics

	Compliance Strategies		
	Organizational	Behavioral	Educational
Age			
Under 35	2.4	3.8	—
36-48	2.2	4.3	—
49-57	1.9	4.2	—
58-67	1.6	3.7	—
Over 68	1.5	2.7	—
	F (4,204) = 2.55*	F (4,204) = 4.24*	—
Year of Graduation			
Pre-1940s	1.5	2.7	1.0
1940s	1.6	3.7	1.3
1950s	1.8	4.1	1.4
1960s	2.2	4.5	1.6
1970s	2.7	4.3	1.6
	F (4,198) = 4.12*	F (4,198) = 6.29‡	F (4,198) = 2.88*
Years in Practice			
0-9	2.5	4.3	—
10-19	2.0	4.3	—
20-29	1.8	4.1	—
30-39	1.6	3.6	—
Over 40	1.6	2.8	—
	F (4,195) = 2.98*	F (4,195) = 4.83‡	—

*$P<.05$
‡$P<.001$
Note: Data for nonsignificant differences have been omitted.

mber of years in present practice (F=2.98, df=4,195, .05 and F=4.83, df=4,195, $P<.05$). Similarly, the mber of strategies used (for all strategy types) was ected positively by year of graduation from medical ıool, with the strongest effects evidenced on the use behavioral strategies (F=6.29, df=4,198, $P<.001$). ıally, the use of compliance strategies was related ectly to previous coursework in patient manage- nt techniques (Table 6). The number of behavioral d educational strategies used was affected positively by previous coursework in patient tracking/monitoring techniques. These educational effects ranged from weak (F=4.04, df=1,161, $P<.05$) to moderately strong (F=13.35, df=1,134, $P<.001$), according to strategy type and level of instruction.*

*A posthoc analysis of variance (factors: type and level of training) failed to show any consistent relationship between number of strategies used (for all strategy types) and type of patient management skill training or between number of strategies used and the level at which the instruction was received.

TABLE 6

Mean Number of Organizational, Behavioral, and Educational Strategies Used Differing Significantly on an Analysis of Variance by Prior Training in Patient Management Techniques

Prior Training	Compliance Strategies		
	Organizational	**Behavioral**	**Educational**
Interpersonal Skills			
Medical School			
No	1.8	—	1.3
Yes	2.4	—	1.6
	F (1,169) = 5.03*	—	F (1,169) = 4.85*
Residency			
No	—	—	1.2
Yes	—	—	1.6
	—	—	F (1,152) = 5.88*
Postgraduate			
No	—	3.6	1.2
Yes	—	4.4	1.5
	—	F (1,138) = 5.67*	F (1,138) = 4.16*
Patient Education			
Medical School			
No	—	3.9	1.3
Yes	—	4.5	1.7
	—	F (1,161) = 4.04*	F (1,161) = 6.35*
Residency			
No	—	3.7	1.2
Yes	—	4.6	1.7
	—	F (1,141) = 6.95†	F (1,141) = 8.57†
Postgraduate			
No	—	3.8	1.2
Yes	—	4.5	1.6
	—	F (1,135) = 5.49*	F (1,135) = 7.56†
Patient Tracking/ Monitoring			
Medical School			
No	—	—	1.4
Yes	—	—	1.9
	—	—	F (1,149) = 7.78†
Residency			
No	1.8	3.6	1.3
Yes	2.6	4.9	1.7
	F (1,137) = 7.45	F (1,137) = 13.35‡	F (1,137) = 5.99*
Postgraduate			
No	—	3.8	1.2
Yes	—	4.7	1.6
	—	F (1,134) = 7.93‡	F (1,134) = 7.16†

*$P<.05$
†$P<.01$
‡$P<.001$
Note: Data for nonsignificant differences have been omitted.

A posthoc analysis of variance (factors: age group, nd level and type of training) indicated that the total mount of variance in the number of strategies used, xplained by age and prior training in patient manage- ient techniques (13 percent), was substantially less ian the sum of these separate effects (22 percent), uggesting the possibility of a relationship between ge and prior training. To examine this, chi-square ests were conducted between age group and level of aining and between age group and type of training. he only significant relationship was found between ge and interpersonal skills training in medical school $c^2 = 11.5$, df= 4, $P<.05$). Specifically, physicians in the oungest age group (36 and under) were more likely o have received such training than those in any of the emaining groups.

UMMARY AND IMPLICATIONS

The survey revealed that most hypertensive patients, n the opinion of their physicians, do not comply fully ith instructions in any of the areas surveyed and how poorest performance in the areas of self-monitor- ng, exercise, and diet. Although almost all respondents urveyed were concerned about patient non- ompliance and used a variety of techniques to easure it, attempts to remedy the problem were lim- ed in scope. The strategy employed most often in ttempts to promote compliance was individual coun- eling by the physician with other educational trategies used less frequently. More than half of the espondents reported using a variety of behavioral trategies including tailoring the treatment to individ- al needs, reinforcement through praise, family in- olvement, and graduated regimens. Fewer respon- ents reported using compliance-promoting organiza- onal strategies, except for scheduling individual as pposed to block appointments.

The analyses also showed that the likelihood of a hysician employing certain compliance-promoting trategies was inversely related to age and number of ears in present practice and directly related to recent raduation from medical school. In addition, the use f certain strategies appeared to be enhanced by revious exposure to educational programs in inter- ersonal relations, patient education, and patient racking/monitoring procedures, with effects varying ccording to type and level of training. Furthermore, interpersonal skills training in medical school appeared to be most common among the youngest physicians, perhaps explaining why this group was most likely to take action against noncompliance. A posthoc analysis of variance failed to show any consistent relationships between the number of strategies used (for all strategy types) and type of patient-management skill training or between number of strategies used and the level at which the instruction was received.

These findings have implications for the education and training of medical students, residents, and practicing physicians. In order to enhance patient-management capabilities, undergraduate, residency, and postgraduate medical programs should expand coursework in patient education, interpersonal skills, and patient tracking/monitoring techniques. In addition, continuing education courses should be developed for the more established physician to stimulate interest in and knowledge of available compliance-promoting strategies. Such programs would be beneficial not only to physicians with large hypertensive patient loads but to those who deal with other chronic conditions where noncompliance typically is problematic.

REFERENCES

1. Caplan RD, Robinson EA, French JR Jr, Caldwell JR, Shinn M: *Adhering to Medical Regimens: Pilot Experiments in Patient Education and Social Support.* Ann Arbor, MI, The Institute for Social Research, The University of Michigan, 1976.
2. Podell RN, Gary LR: Compliance: A problem in medical management. *Am Fam Physician* 13:74-80, 1976.
3. Finnerty FA Jr: The compliance problem in hypertension, in Freis ED (ed) in *Current Status of Modern Therapy (Volume 1).* Baltimore, MD, University Park Press, 1978, pp. 151-160.
4. Haynes RB, Gibson ES, Hackett BC, Sackett DL, Taylor DW, et al.: Improvement of medication compliance in uncontrolled hypertension. *Lancet* 1:1265-1268, 1976.
5. Hussar DA: Patient noncompliance. *J Am Pharm Assoc* 15:183-190, 1975.
6. Haynes RB, Mattson ME, Englebretson TO Jr: Trends in the implementation of strategies to improve compliance in hypertensives, in *Patient Compliance To Prescribed Antihypertensive Medication Regimens: A Report to the National Heart, Lung, and Blood Institute.* DHHS Publication No. (NIH) 81-2102. Washington, D.C., U.S. Government Printing Office, 1980, pp. 165-228.
7. Oppenheim AN: *Questionnaire Design and Attitude Measurement.* New York, NY, Basic Books, Inc., 1966, pp. 33-35.

The RCA solution for paperwork headaches.

Introducing the cure to all your administrative headaches. The Medical Management System from RCA. This unique system was designed by a physician for physicians. It handles everything from insurance claims and patient billing to invoice tracking and cash disbursements. It takes the hassle out of time-consuming billing procedures and gives you greater control of the business side of your practice.

You'll feel good about the RCA Medical Management System when you see the price, too. It's affordable. Easy to use. And includes an IBM personal computer, a high-capacity disc storage unit, a printer, and the RCA Medical Management software.

We'll take care of everything — delivery, installation and user training. And the entire system is backed by RCA's one-year, on-site service warranty.

Make an appointment today to see a special demonstration of the RCA Medical Management System. Just call collect **(609) 338-4129** and let RCA help make your practice perfect.

RCA Data Services



Case Report: Hyperprolactinemia in a Patient with Pseudotumor Cerebri

Michael Goldman, M.D., and Aaron Rabin, M.D., Englewood*

Hyperprolactinemia has been associated with many intracranial disorders including sella and parasella tumors and the empty-sella syndrome. This case report documents the occurrence of hyperprolactinemia in a patient with pseudotumor cerebri.

Hyperprolactinemia has been associated with multiple conditions. These include pituitary tumors, the empty-sella syndrome, drug ingestion, and hypothyroidism.[1] The occurrence of elevated prolactin levels in a patient with pseudotumor cerebri has not been described previously. A case describing this situation is presented.

CASE HISTORY

A 26-year-old white female complained of blurred vision described as "spots in front of her eyes." No other symptoms were described. Her past medical history was notable for irregular menses (every six to ten weeks) without galactorrhea. She had taken tetracycline for three years for acne, although it was discontinued three months before admission. Physical examination revealed the patient to be slightly overweight (125 pounds) with a blood pressure of 120/80 and a regular pulse at 72. Except for bilateral papilledema, no other abnormal findings were noted. CAT scans of the head and pituitary gland with and without contrast were normal. Formal visual fields were normal. Measurement of a lumbar puncture showed an opening pressure of 450 mm of water (normal 180). The cerebrospinal fluid was clear with a normal chemical profile. Laboratory data revealed a normal CBC, SMA 12, electrolytes, T_3 resin, T_4, TSH, parathyroid hormone, and calcium levels. Prolactin was elevated to 31.4 ng/ml (normal: 6 to 22). The patient was treated with Lasix®, 40 mg daily, with reduction of her symptoms. No change in her menstrual activity was reported. Prolactin was not remeasured during this time.

Three months later, she returned with her original complaint, and mild bilateral papilledema again was noted. A repeat lumbar puncture showed an elevated pressure of 410 mm of water with normal fluid analysis. Further laboratory data demonstrated a normal level of cortisol, dehydroepiandrosterone sulfate, T_3 resin, and T_4. LH measured 10 MIU/ml (normal 7 to 24) while FSH was a 3 MIU/ml (normal 4 to 25). Prolactin again was elevated at 64 ng/ml. The patient then was treated with Diamox®. Improvement of her papilledema was noted along with diminution in the severity and frequency of her original visual complaint.

DISCUSSION

Increased prolactin levels may result from intracranial problems (pituitary tumors and the empty-sella syndrome), extracranial causes (drug ingestion and hypothyroidism), or unknown ("idiopathic") etiologies.[1] The association of increased prolactin levels and pseudotumor cerebri has not been reported

*From Englewood Hospital where Dr. Goldman is Attending, Department of Medicine, and Dr. Rabin is Attending, Department of Neurology. Correspondence may be addressed to Dr. Goldman, 600 Palisade Avenue, Englewood Cliffs, NJ 07632.

previously. One case report noted elevated prolactin levels in the patient with the empty-sella syndrome who had a history of pseudotumor cerebri.[2]

Pseudotumor cerebri is defined as a constellation of symptoms and signs including headache, papilledema, and increased intracranial pressure from causes generally thought to be benign.

Some authors feel that chronic raised intracranial pressure may lead to an empty-sella syndrome.[3] Etiologies (through uncertain mechanisms) for pseudotumor cerebri, include endocrine and nonendocrine causes. The former include adrenal, ovarian, parathyroid, or thyroid dysfunction, and the latter include drugs (such as tetracycline) and intracranial venous thromboses. However, abnormalities in prolactin secretion have not been reported.

The coexistence of pseudotumor cerebri and pituitary tumors or empty-sella syndrome to account for the elevated prolactin levels was excluded by a normal CAT scan of the pituitary gland. Similarly, secondary causes for increased levels (drugs and hypothyroidism) were excluded by our studies. T role of the elevated prolactin level in this relationsh to pseudotumor cerebri remains speculative at t present time.

SUMMARY

A case of pseudotumor cerebri and hyp prolactinemia is reported. This association has n been described previously and should be added to t list of syndromes found to have elevated prolact levels.

REFERENCES

1. Kleinberg DL, Noel GL, Frantz AG: Galactorrhea: A stu of 235 cases, including 48 with pituitary tumors. *N Eng Med* 296:589-600, 1977.

2. Futterweit W: Galactorrhea, amenorrhea, hyp prolactinemia, and pseudotumor cerebri in a patient wi primary empty-sella syndrome: Case report with review of t literature. *Mt Sinai J Med* 49(6):514-518, 1982.

3. Foley KM, Posner JB: Does pseudotumor cerebri cau the empty-sella syndrome? *Neurology* 25:565-569, 1975.

PHARMACOLOGICAL BASIS OF THERAPEUTICS: EICOSANOIDS—MEDIATORS OF BIOLOGICAL FUNCTIONS*

DONALD J. WOLFF, PH.D., PISCATAWAY**

Eicosanoids are locally generated and locally acting hormones most commonly derived from arachidonic acid—a precursor of two major classes of biological regulatory molecules: prostaglandin-like substances and leukotrienes.

Eicosanoid is a term used to describe a series of locally generated and locally acting hormones or autocoids which are oxidative metabolites of endogenous 20-carbon, unsaturated fatty acids. The most common such fatty acid in humans is arachidonic acid (5,8,11,14 eicosatetraenoic acid). Arachidonic acid is chemically released from membrane-bound phospholipid by hydrolysis catalyzed by the enzyme phospholipase A_2. The activity of phospholipase A_2 is enhanced by Ca^{2+} whose concentrations intracellularly are elevated in response to diverse mechanical and neurohumoral stimuli. The arachidonic acid thus generated serves as the metabolic precursor of two major classes of biological regulatory molecules, the prostaglandin-like substances and the leukotrienes (Figure).

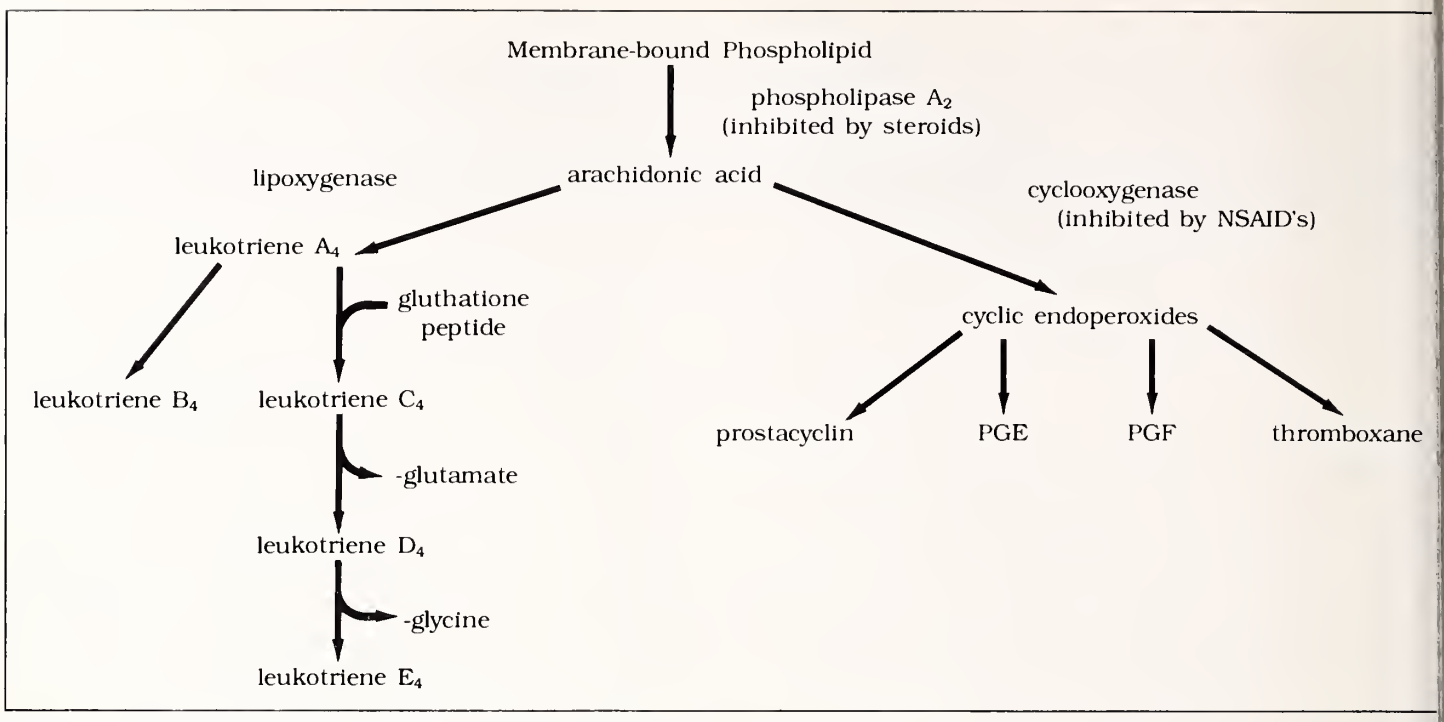
CYCLOOXYGENASE

The prostaglandin-like substances depend for their formation on the actions of an enzyme cyclooxygenase, bound to intracellular membranes, which introduces O_2 into the fatty acid at carbon 15 and effects a cyclic rearrangement of its carbon atoms. This action forms substances called cyclic endoperoxides which are subject to four different types of isomerization reactions to generate, respectively, prostacyclins, thromboxanes, or prostaglandins of the E or F series. Different cells produce a different spectrum of these products depending upon the constitutive level of isomerases characteristic of the particular type of cell. The prostaglandin-like substances can be produced by virtually every tissue and have been implicated as mediators of an impressively diverse array of functions. Furthermore, diverse pathological states are accompanied by alteration of their concentrations, which are proposed to contribute in part to the discomforting symptomatology of these conditions. For example, elevated endometrical prostaglandin $F_{2\alpha}$ accompanies primary dysmenorrhea,[1] elevated prostaglandin E_2 accompanies pyrogen-induced fever,[2] and elevated prostaglandins are found in synovial fluid in diverse arthropathies.[3]

Interest in the prostaglandin-like substances has been enhanced by the observation that aspirin and the

*This article, third in a series, prepared under the leadership of Bruce McL. Breckenridge, M.D., Chairman, Department of Pharmacology, UMDNJ-Rutgers Medical School, is a brief review of recent advances in pharmacology and related preclinical sciences, which will help readers to understand the action of new and established therapeutic agents. The reviews do not consider indications for specific drugs, incompatibilities, or dosage forms, which can be found in the *AMA Drug Evaluations, 5th Edition*, 1983.

**From the Department of Pharmacology, UMDNJ-Rutgers Medical School, Piscataway, NJ 08854. Correspondence may be addressed to Bruce McL. Breckenridge, M.D., Chairman, Department of Pharmacology, UMDNJ-Rutgers Medical School, P.O. Box 101, Piscataway, NJ 08854.



Figure—Pathways for generation of eicosanoids.

rapidly growing number of nonsteroidal anti-inflammatory drugs are specific inhibitors of cyclooxygenase.[3] The rank order of potency of these drugs inhibiting cyclooxygenase in vitro parallels their potency as anti-inflammatory agents in vivo. Furthermore, several of these drugs exist as stereospecific isomers, with only one isomer showing both activities. Compatible with the proposal that inhibition of cyclooxygenase is the molecular basis of action of nonsteroidal anti-inflammatory drugs is the clinical observation that these agents, of widely varying chemical structure, are uniformly antipyretic and capable of alleviating the discomforting symptomatology of both primary dysmenorrhea and diverse arthropathies.

A major advance in appreciating the role of arachidonic acid derivatives in diverse pathophysiological states emerged from studies directed to understanding the molecular basis of action of the anti-inflammatory steroids. In 1979, Hirata and his colleagues reported the observation that anti-inflammatory steroids induced in neutrophils the synthesis of a membrane-bound protein inhibitor of the enzyme phospholipase A_2, the enzyme responsible for the intracellular release of arachidonic acid.[4] They called this inhibitor, lipomodulin. Glucocorticoids had been known for many years to alleviate the symptomatology of asthma, immediate hypersensitivity reactions, and diverse inflammatory states. These actions are more extensive than those of aspirin and the nonsteroidal anti-inflammatory drugs and suggested that derivations of arachidonic acid, generated by a pathway other than the cyclooxygenase pathway, might be involved in genesis of these drug actions. These speculations are supported by the recent elucidation of a second pathway for arachidonic acid oxygenation in leukocytes.

LEUKOTRIENES

In an attempt to identify products generated from arachidonic acid in inflammatory cells, polymorphonuclear leukocytes were exposed to C^{14}-labele material. Using reverse-phase high pressure liqui chromatography, Samuelsson and coworkers identi field the formation of a key intermediate 5,(oxido-7,9,11,14 eicosatetraenoic acid (leukotriene A_4 in a new metabolic pathway.[5] Leukotriene A_4 now i known to have two major metabolic fates. It can b hydrolyzed to form leukotriene B_4 or alternately ca react with the endogenous tripeptide, glutathione, t form a peptidolipid called leukotriene C_4. The amin acids glutamic acid and glycine can be removed se quentially from this structure by intracellula proteases to form leukotrienes D and E. The ter leukotriene was chosen for these compounds becaus they were discovered in leukocytes and contain as common structural feature a conjugated triene Samuelsson and his coworkers established that slow reacting substance of anaphylaxis, a potent smooth muscle contracting substance released during asthmatic attacks and other types of immediate hypersensitivity (allergic) reactions, was a mixture o leukotrienes C, D, and E. The proposed structures fo leukotrienes have been confirmed by total chemica synthesis. Such syntheses have made available large quantities of purified leukotrienes for determination of their biological effects and refinement in the techniques for their specific assay.

The peptidoleukotrienes C, D, and E have been shown to be extraordinarily potent bronchoconstrictors in man.[6] When administered as an aerosol, they are 100 times as potent as histamine. Studies with bronchi from atopic patients sensitive to birch pollen have implicated leukotrienes as mediators of anaphylaxis. Incubation of atopic lung tissue with allergen resulted in formation of leukotrienes C, D, and E. Their formation was blocked by an experimental drug, U-60257, at concentrations which blocked allergen-induced tissue contraction. Histamine antagonists and cyclooxygenase inhibitors were ineffective. These findings suggest that leukotriene antagonists, or inhibitors of leukotriene formation, could

of value in the treatment of bronchial asthma.

Recent studies, in animal systems, have identified ofound microvascular actions of the pep-loleukotrienes. Using a hamster cheek pouch prep-ation in vivo, leukotrienes C, D, and E all induced creased vascular permeability at concentrations five ousand-fold lower than histamine.[7] These bstances produced intense contraction of terminal terioles and endothelial leakage at postcapillary nules, actions compatible with their involvement in ema formation in local, acute inflammatory isodes.

Other studies have identified leukotriene B as an tivator of human neutrophils and as a potent iemotactic substance toward polymorphonuclear ukocytes, eosinophils, and monocytes.[8] The potential volvement of leukotrienes as mediators of immediate persensitivity reactions and inflammation seem ob-ous. The development of specific, in vivo, antagonists leukotrienes and further elucidation of the mecha-sm of their formation and action rigorously is being ught and shows promise for the development of new seful therapeutic agents.

JMMARY

Eicosanoids are locally generated and locally acting ormones derived metabolically from naturally occur-ng 20-carbon, unsaturated fatty acids, most com-only arachidonic acid. Arachidonic acid is a recursor of two major classes of biological regulatory olecules, the prostaglandin-like substances and the recently characterized leukotrienes. Leukotrienes have been identified as extraordinarily potent bronchoconstrictors, leukocyte chemoattractants, and regulators of microvascular tone and permeability. Their formation is believed responsible for much of the symptomatology of acute allergic reaction, bronchial asthma attacks, and aspirin sensitivity.

REFERENCES

1. Chan YW: Prostaglandins and nonsteroidal anti-inflammatory drugs in dysmenorrhea. *Annu Rev Pharmacol Toxicol* 23:131, 1983.

2. Feldberg W, Gupta KP: Pyrogen fever and prostaglandin-like activity in cerebrospinal fluid. *J Physiol* 228:41, 1973.

3. Moncada S, Vane JR: Mode of action of aspirin-like drugs. *Adv Intern Med* 24:1, 1979.

4. Hirata F, Schiffmann E, Krishnamoorthy V, Salomon D, Axelrod J: A phospholipase A_2 inhibitory protein in rabbit neutrophils induced by glucocorticoids. *Proc Natl Acad Sci* 77:2533, 1980.

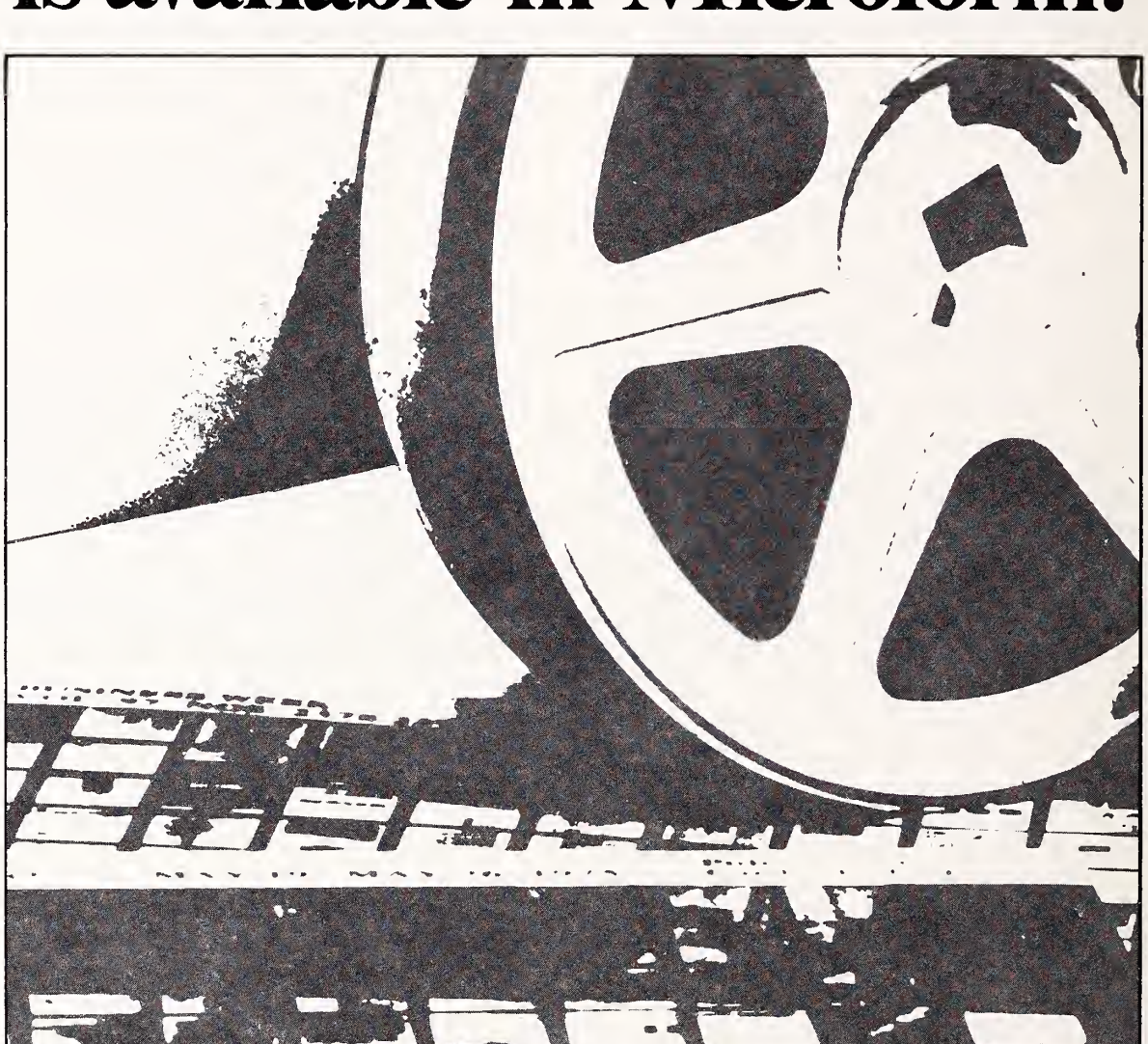
5. Samuelsson B: Leukotrienes: Mediators of immediate hypersensitivity reactions and inflammation. *Science* 220:568, 1983.

6. Weiss JW, Drazen JM, Coles N, McFadden ER, Willer PF, Corey EJ, Lewis RA, Austen KF: Bronchoconstrictor effects of leukotriene C in humans. *Science* 216:196, 1983.

7. Hedgvist P, Dahlen SE: Pulmonary and vascular effects of leukotrienes imply involvement in asthma and inflammation, in Samuelsson B, Paoletti R, and Ramwell PW (ed): *Advances in Prostaglandin, Thromboxane, and Leukotriene Research*. 1982.

8. Ford-Hutchinson AW, Bray MA, Doiy MV, Shipley ME, Smith MH: Leukotriene B, a potent chemokinetic and aggregating substance released from polymorphonuclear leukocytes. *Nature* 286:264, 1980.

This Publication is available in Microform.



Please send additional information for_____
(name of publication)

Name_____

Institution_____

Street_____

City_____

State_____ Zip_____

300 North Zeeb Road, Dept. P.R., Ann Arbor, Mi. 48106

University Microfilms International

MPAIRED PHYSICIANS PROGRAM: 'REATMENT LOAN FUND

)AVID I. CANAVAN, M.D., LAWRENCEVILLE*

The Treatment Loan Fund of the Impaired Physicians Program helps physician-clients in their time of need. Loans are used for treatment costs, family support during treatment, and re-entry expenses. Contributions for this fund are welcomed.

One of the challenges that confronts us in our efforts on behalf of the "wounded healers" in our idst is the economic consequences in the life of the ipaired physician. As the diseases of impairment ogress, his professional performance, his good judgent, and the successful management of his personal ances are affected.

In the face of declining patient revenues, judgmental rors, and lack of attention to appropriate life mangement, it is not at all surprising that economic chaos equently accompanies all of the other problems that sue.

In our efforts to find suitable therapy for these ients, we often are thwarted by their own economic stress. One of the first things that seems to go when nances get tight is the physician's own medical d/or hospital insurance coverage.

Since the passage of the ATRA (Alcohol Treatment d Rehabilitation Act) legislation in the late 1970s, e insurance carriers in New Jersey have been reuired to provide coverage for treatment of alcoholism. hen a physician has current coverage, the economic rden of inpatient treatment is minimal. In the situion in which the physician's insurance has been lowed to lapse, the cost of the treatment often prests an economic burden that the physician-client nnot meet.

An added burden in these cases is the need to take time away from a practice that already may be economically compromised. In these situations, time away from the office can lead to an absence of income to meet the needs of the family for economic support.

Both the lack of insurance and the economic distress of the family are major obstacles in convincing our colleagues to accept the time requirement and the economic implications of admission to an inpatient program.

It is possible in some cases to compromise and accept an outpatient program as the only viable alternative, but this is not necessarily the preferred route.

Even in the case of an actively employed physician, the occasional need for long-term therapy (e.g. four to six months of residential treatment) can lead to serious cash-flow problems.

It was precisely because of these problems that the concept of a Treatment Loan Fund surfaced. In my travels around the country, interacting with other state impaired physicians programs, this same issue regularly has surfaced as a common problem and the need for a vehicle to assist physicians is readily perceived.

*Dr. Canavan is Medical Director, Impaired Physicians Program. Correspondence may be addressed to Dr. Canavan, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648.

Since my arrival in Lawrenceville in September 1982, I have pursued actively the acquisition of funds for this purpose. My initial efforts were directed to the pharmaceutical houses that are based in New Jersey. I personally contacted ten companies and was successful in obtaining contributions to our fund from five of these. To date, these contributions amount to $19,250 with an additional $17,000 pledged over the next two years.

Two other organizations whom I addressed about our New Jersey program provided an additional $350 for our fund.

We recently have developed a policy of allocating interest on a monthly basis to the unused grant funds from our generous program supporters. This interest will be credited to the Treatment Loan Fund.

The monies in this fund are available to physician-clients of our program who are in real need. The funds will be provided to the physicians as low-interest (3 percent per annum) loans.

At the end of the first year, the accrued interest will be due and payable. Thereafter, one-twelfth of the balance and the month's interest on the unpaid balance will be due and payable at the end of each subsequent month until the balance is paid in full.

Loans may be made for any valid purpose, but ideally would be limited to: treatment costs; family support during treatment; and re-entry expenses (e.g. malpractice premiums, family support, relicensure costs).

At present, four loans have been made to cover family expenses and malpractice premiums.

Our goal is to establish a fund of $100,000 which would function as a revolving loan fund and it would be maintained by MSNJ's financial officer. Income from the fund balance, interest, and loan repayments would be used to maintain the fund and to offset any bad debts generated.

In approaching the pharmaceutical corporations recurrent issue has been—what are the doctors the selves doing to support this fund? I have had to answ that until recently they have not been asked to parti pate. Corporate donors have indicated that they wou be more willing to participate with the physicians th in place of the physicians.

For this reason, we asked the Board of Trustees f approval to solicit our membership for voluntary co tributions to the Treatment Loan Fund. This w granted and an ad appeared in the September 19 issue of *The Journal* soliciting voluntary contrib tions to the fund. I was overwhelmed by the lack response. Not one member of *The Journal* audien responded to our ad.

This has prompted me to write the article detaili exactly what the Treatment Loan Fund is, how evolved, what our current status is and what our go are.

I hope you are encouraged to contribute to our fu for your suffering colleagues in their hour of need! gift is too small (or too large). If you are involved wi charitable agencies, funds, or foundations that a seeking appropriate grantees, please plead our cau or let us know how to do it for you. If you are looki for additional bequests to add to your will, we wou be happy to find that this fund has been include

To start the ball rolling, I am personally making donation of $100 to the fund. Won't you consider f lowing suit within your own ability to do so?

Contributions can be made to the Medical Socie of New Jersey, Impaired Physicians Program, Tre ment Loan Fund and may be mailed to: Impaired Ph sicians Program, Medical Society of New Jersey, Tv Princess Road, Lawrenceville, NJ 08648.

We'll keep you posted on the results of this endeav

Trustees' Minutes; UMDNJ Notes; AMNJ Report; New Members; Physicians Seeking Location in New Jersey

rustees' Minutes: pril 15, 1984

A regular meeting of the Board of ustees was held on April 15, 1984, the Executive Offices in Lawnceville. Detailed minutes are on e with the secretary of your county edical society. A summary of sigficant actions follows:

eport of the President . . .
gislation . . . Noted that a comunication from the Union County edical Society stated that efforts of e Council on Legislation should ncentrate on the successful pasge of professional liability bills.

eport of Executive Director . . .
) MSNJ Paid Membership . . . oted that as of March 31, a total of 508 members have paid 1984 ues.
) MSNJ Financial Statements . Reviewed and approved nancial statements for the period ding March 31, 1984.
) Corporate Practice of Medicine . Reiterated opposition to hospil-owned "for profit" corporations.
) State Board of Medical Examiners Proposed Ruling on Chiropractic Practice . . . Voted to oppose adoption of proposed rule N.J.A.C. 13:35-7.1 which expands standards and scope of chiropractic practice.
(5) Legal Services Plan . . . Referred to the Committee on Medical Defense and Insurance Dr. Rigg's report on the Legal Services Plan. Approved then the following recommendation with the understanding that the Committee will continue to monitor the Legal Services Plan:

> That the Legal Services Plan be continued in its present form, since it provides high quality legal services at a modest expense to the members of the Society.

(6) Litigation . . .
(a) Exclusive Anesthesia Contracts . . . Noted the U.S. Supreme Court upheld the legality of exclusive anesthesia contracts.
(b) Mandatory Participation in Blue Shield and Ban on Balance Due Billing . . . Noted that a Massachusetts Federal District Court ruled that Blue Shield Plan's ban on balance due billing and refusal to pay for services of nonparticipating physicians violates federal antitrust law.
(7) New Jersey Resident Physician Selection . . . Authorized attendance of official representative of NJ Resident Physician Section at MSNJ Annual Meeting and $1,000 to offset expenses of two resident physician delegates at AMA Annual Meeting—in an effort to encourage membership.
(8) Study of DRG System . . . Noted that the federal government has contracted with Harvard School of Public Health to study the feasibility of a physician DRG system of reimbursement.

UMDNJ . . .
Fradulent Documentation . . . Noted Dr. Bergen's report on fraudulent documentation of background and credentials of individuals in residency programs and noted there is no documented evidence of impropriety in New Jersey at this time.

Ad Hoc Committee on Presentation of MSNJ DRG Position . . . Approved the following five recommendations:

(1) That two or three knowledgeable individuals from outside the state of New Jersey be invited to meet with the Ad Hoc Committee, to discuss concerns about DRGs, as an approach in aiding the Ad Hoc Committee in the presentation of the MSNJ DRG position.

(2) That a seminar be held on DRG some time in the early fall, sponsored by the Medical Society of New Jersey.

(3) That the Medical Society of New Jersey continue to request an objective investigation of the DRG Program in New Jersey, including necessary legislative activity to further this investigation.

(4) That the Medical Society of New Jersey investigate knowledgeable and interested groups to develop alternative methods of pricing or reimbursement, and that the staff be asked to investigate methods of implementation.

(5) That recent articles published in *The New York Times* (March 5 and March 18 issues) on DRGs be sent to the membership of the Medical Society of New Jersey, specialty societies, and legislative people through the state. The option of whether the articles are sent in complete or summary form is to be at the discretion of staff.

Also, suggested that copies of a proposed DRG survey be sent to members of MSNJ's DRG Committee.

Proposed Standards for Licensure of Ambulatory Care Facilities . . . Approved a recommendation to arrange a meeting with the Commissioner of Health and his staff, representatives from MSNJ, and representatives of the NJ Academy of Family Physicians regarding the revision of the *Manual of Standards for the Licensure of Ambulatory Care Facilities.*

Council on Medical Services . . .
Corporate Restructuring of New Jersey Hospitals . . . Approved the following recommendation:

> That the Medical Society of New Jersey maintain that the assets of hospital corporations which have been and are being unbundled should have those revenues and assets of the unbundled corporations included in the assets and income of the hospital for which the rate development of the hospital itself is based.

Committee on Medical Aspects of Sports . . .
Physical Therapy Modalities/Unlicensed Aides . . . The following recommendation was referred back to the Committee:

> That the Board of Trustees advise the State Board of Medical Examiners that

the suggested regulation regarding physical modalities used by unlicensed physician's aides is unacceptable as written, and it neither would be beneficial nor practical to put the regulations into effect.

Note: The Committee objected to the aides being restricted from doing rehabilitative exercises, that the physician must see the patient each time physical treament is given, and that the physician must be on the premises when physical therapy orders are being carried out; the Committee felt the regulation was for the advantage of physical therapists not for the benefit of the patient.

Committee on Conservation of Vision . . .
1984 Eye Health Screening Week . . . Approved the following recommendation:

That the Eye Health Screening Program be conducted during the week of September 17, 1984.

Ad Hoc Committee on Study on PRO . . . Approved the following recommendation:

That there be a formal bylaw relationship with the PRO Federation, including the Medical Society of New Jersey and the New Jersey Association of Osteopathic Physicians and Surgeons, and that there be official representation on the Board of Trustees of the PRO Federation. (Or, that some similar relationship be advanced.)

Committee on Finance and Budget . . . Approved the following recommendations:

(1) That the budget for the fiscal year beginning June 1, 1984, and ending May 31, 1985, in the amount of $2,783,400 with $2,062,500 to be raised through member assessments be adopted.
(2) That the 1985 assessment be set at $275 per regular dues-paying member. (No change)
(3) That the 1985 assessment be set at $25 per member for affiliate (no longer practicing in New Jersey) and associate members (interns-residents nonlicensed in New Jersey). (No change)
(4) That there be an assessment for 1985 of $25 per member for licensed residents provided the individual is in a residency program entered upon within a reasonable time after his or her graduation from medical school. (No change)
(5) That the 1985 assessment be set at $10 per student for medical students. (No change)

Also, approved the following two recommendations:

That reimbursement of hotel cost be made at a maximum rate of $100 per day.

That reimbursement for land travel be made at the maximum rate of $125 per trip.

Old Business . . .
Hospital Medical Staff Regulations . . . Noted that at Hamilton Hospital the governing board has requested the medical staff to draft a revision of bylaws.

New Business . . .
AMA Ad Hoc Committee on Foreign Medical Graduates . . . Directed that the name Frank Campo, M.D., be submitted for nomination to the AMA Ad Hoc Committee on Foreign Medical Graduates to study the problems and concerns of foreign medical graduates.

UMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

At its 11th annual commencement on May 23 at the Garden State Arts Center, the University awarded honorary Doctor of Science degrees to three persons who have made outstanding contributions in the health sciences. They were:

Dr. Carolyne Kahle Davis, administrator of the federal Health Care Financing Administration. Dr. Davis, who has degrees in nursing, nursing education, and higher education administration, was at the University of Michigan as associate vice-president for academic affairs and dean of the School of Nursing before joining the federal agency. From 1957 to 1960, she was a nursing instructor at Mercer Hospital in Trenton.

Dr. Roy P. Vagelos, president of Merck, Sharp and Dohme Research Laboratories, Rahway, whose research contributions at the National Institute of Health, as biochemistry chairman at the Washington University School of Medicine, and at Merck focused on fatty acids.

Dr. Elizabeth Boggs of Hampton, first woman president of the National Association for Retarded Citizens and former president of the New Jersey unit, whose full-time volunteer advocacy played a key role in the passage of federal legislation for the developmentally disabled and the securing of the rights of the handicapped.

UMDNJ's six schools produc more than 600 trained personnel f the health sciences professions th year, including about 260 in t medical-dental fields.

It is gratifying to be able to rep that all 289 members of the Univ sity's medical school graduati class have secured graduate medi education appointments.

Of the 1984 class, 254 prospect graduates, or 88 percent, obtain residencies through either t American Medical Association's N tional Resident Matching Progra for UMDNJ-New Jersey Medi School and UMDNJ-Rutgers Medi School or the American Osteopath Association's Intern Registrati program for UMDNJ-School of O teopathic Medicine. The other students obtained residenci outside of the match programs.

The percentage of match parti pants obtaining residencies with New Jersey rose to 44 percent, fr the decline to 38 percent record for 1983 graduates. The School Osteopathic Medicine showed t largest increase here, reaching percent of the class of 1984 against 43 percent of the class 1983.

Within the integrated reside programs at UMDNJ's core teachi hospitals, the percentage of Unit States graduates among the re dents recruited continued to clin reaching 85.2 percent. The numb of U.S. graduates of foreign medi schools dipped to 11.5 percent, wh the number of foreign medi school graduates remained virtua stable at about 3 percent.

The more intense competition f residencies is reflected in the fa that less than half of the allopath match participants obtained the first choice. For the class of 198 the percentage going to their firs choice institutions is 44 perce while more than half of the class of 1982 and 1983 got their fi choice. Comparisons for osteopath students are not available.

Medical advances at UMD schools are helping couples w want to become parents of healt babies. A new diagnostic techniq that can detect genetic disorders the fetus as early as seven or eig weeks into a pregnancy is being fered by the UMDNJ-New Jers Medical School.

The procedure, known

ıorionic villi sampling (CVS), is ›nsidered a breakthrough because can be employed at an early stage pregnancy and because it involves › penetration of the patient's ab›minal or uterine walls. The ocedure, being tested nationally ıder strict federal guidelines, is ›ne on an outpatient basis at Uni-ersity Hospital, which is adjacent to ıe medical school on the Newark ımpus.

Thus far CVS has proved at least 5 percent accurate in detecting own's syndrome, Tay-Sachs dis-ase, sickle cell anemia, and other enetic abnormalities that were reviously diagnosed prenatally only y the process of amniocentesis. owever, amniocentesis cannot be ›ne until the 16th week of preg-ancy and requires a needle to be ıserted through the abdomen into ıe sac surrounding the fetus.

Another prenatal test to detect ippling and often fatal congenital ›normalities of the embryonic neu-al tube, which eventually forms the rain, spinal cord, and spinal ›lumn of the fetus, now is available t both UMDNJ-New Jersey Medical chool and UMDNJ-Rutgers Medical chool in New Brunswick.

The prenatal test, most accurate hen done 16 to 20 weeks into the regnancy, is a simple blood test for lpha-fetoprotein (AFP), a serum rotein normally produced almost xclusively in fetal life.

Neural tube disorders, among the ıost common congenital birth de-ects in this country, include nencephaly, the absence of brain nd spinal cord, which is always ıtal; spina bifida, which results in arying extents of paralysis and rain damage; and hydrocephalus, n accumulation of fluid on the rain, which can be corrected urgically.

At UMDNJ-School of Osteopathic Medicine in Camden/Cherry Hill, he first applicants for in vitro ertilization are being accepted. Con-ducted in cooperation with the chool's core teaching affiliate, Ken-nedy Memorial Hospitals-University Medical Center, Cherry Hill Division, his is the first so-called "test tube ›aby" program in the United States o be conducted by an osteopathic chool.

This is the second program in New Jersey, and the second for UMDNJ, o attempt to overcome infertility problems by a procedure that unites a woman's egg with her husband's sperm in a laboratory. Achievement of its first two pregnancies has been reported by the in vitro program conducted by UMDNJ-Rutgers Medical School with Middlesex General University Hospital, New Brunswick.

AMNJ Report

Paul J. Hirsch, M.D.
President

The Board of Trustees of the Academy of Medicine of New Jersey has voted unanimously to grant a special award, for contributions to continuing medical education, to Sylvan E. Moolten, M.D. Dr. Moolten is well known for organizing high-quality continuing education courses. For many years he ran a weekly Wednesday morning program, attended by physicians from all over the state. This course, held at Middlesex General Hospital, was a standard for continuing physician education. Dr. Moolten retired last year, as director of this postgraduate course, which now permanently bears his name. This special award was granted at the Academy of Medicine's Annual Awards Dinner on May 23, 1984.

The Award to Dr. Moolten was in addition to the two major awards which are granted on an annual basis by the Academy of Medicine. As previously announced, Alfred A. Alessi, M.D., received the Edward J. Ill Award; and Congressman James Courter received the Citizen's Award.

Joseph Ruggles, Associate Director for Continuing Education, has now assumed his office at the Academy of Medicine. Mr. Ruggles will be in charge of developing new educational programs, developing programs which utilize new and innovative techniques, and assessing the educational needs and wants of the membership of the Academy of Medicine.

At the recent meeting of the Board of Trustees of the Academy of Medicine, final approval was given to a change in the bylaws, which now permits application for membership in the Academy of Medicine to be made without the need for sponsorship by Academy members. This is consistent with the Board's policy of encouraging a broad-based membership in the Academy of Medicine. This will allow the Academy to continue to provide very high-quality educational programs and activities for the physicians of New Jersey, at low cost. We believe that the Academy of Medicine deserves the support of the physicians of our state; and particularly encourages members of the Medical Society of New Jersey to become members of this teaching arm of the Medical Society of New Jersey.

New Members

The Journal would like to welcome the following new members to the Medical Society of New Jersey:

Bergen County
Avrill R. Berkman, M.D., Hackensack
Nicholas V. Campanella, M.D., Fair Lawn
James A. Cocores, M.D., Wayne
Arthur R. Crowley, M.D., Teaneck
Anne-Marie Filkin, M.D., Leonia
Ivan A. Friedrich, M.D., Englewood
Harry Katz, M.D., Ridgewood
Andrew Kunish, Jr., M.D., Fair Lawn
Joseph M. Parian, M.D., Lodi
Asmat U. Quraishi, M.D., Teaneck
Carl J. Renner, M.D., Hasbrouck Heights
William D. Salerno, M.D., Saddle Brook
Howard S. Smith, M.D., Ridgewood
Anita D. Winokur, M.D., Hackensack

Burlington County
Douglas Jay Cohen, M.D., Mount Laurel
Richard K. DeVeaux, M.D., Moorestown
Joseph F. Girone, M.D., Marlton
Robert W. Goldlust, M.D., Willingboro
Isabel C. Guerrero, M.D., West Trenton
Eric N. Kruger, M.D., Medford
James C. Peters, M.D., Mount Holly
Scott R. Sharetts, M.D., Willingboro
Gerald J. Ukrainski, M.D., Moorestown
John Y. Yang, M.D., Maple Shade

Camden County
Ilene S. Cottler, M.D., Cherry Hill
Miguel L. deLeon, M.D., Cherry Hill
Edward J. Gallagher, M.D., Somerdale
Michael B. Goldstein, M.D., Cherry Hill
Russell S. Golkow, M.D., Stratford
Glenn S. Merewitz, M.D., Cherry Hill
Barry M. Miskin, M.D., Collingswood
Nancy Ruth Otto, M.D., Camden
S. Habeebur Rahman, M.D., Cherry Hill
Larry S. Rosen, M.D., Cherry Hill
Joseph F. Rubacky, M.D., Blackwood
Tariq Sifat Siddiqi, M.D., Gibbsboro
Linda Stanley, M.D., Marlton

Essex County
Alan H. Burghauser, M.D., Elizabeth
Leslie M. Greenberg, M.D., Mooristown
Bernard J. Lehrhoff, M.D., Millburn
Issac O'Neal, M.D., East Orange
Andrew B. Stefaniwsky, M.D., Maplewood

Gloucester County
Fiore J. Coparc, M.D., Sewell
Norman Feinsmith, M.D., Woodbury
Alan Lawit, M.D., Woodbury Heights

Mark A. Lebovitz, M.D., Woodbury
David I. Olian, M.D., Woodbury

Hudson County
Fred P. Doyle, M.D., Secaucus
John J. Hosay, M.D., Jersey City
Monica Mehta, M.D., Jersey City
Bernard I. Reimer, M.D., Hoboken
Stephen Thomsen, M.D., Union City
John J. Ursino, M.D., Jersey City

Hunterdon County
Allen J. Kern, M.D., Clinton
Austin H. Kutscher, M.D., Flemington

Mercer County
Louis G. Fares, M.D., West Orange
Timothy C. Gjenvick, M.D., Hightstown
Farid F. Muakkassah, M.D., Trenton
Mark J. Tenenzapf, M.D., Trenton

Middlesex County
Pammi T. Bais, M.D., Edison
Steven Deak, M.D., New Brunswick
Lawrence D. Frenkel, M.D., New Brunswick
Enrique A. Rodriguez Paz, M.D., Middlesex
Larry E. Shindelman, M.D., Highland Park

Monmouth County
Savji L. Bhatiya, M.D., Little Silver
Steven M. Feld, M.D., Neptune
Sung W. Paik, M.D., Neptune City
Lewis A. Preschel, M.D., Freehold
David J. Sharon, M.D., Long Branch

Morris County
Emil P. Bisaccia, M.D., Morristown
Anthony F. Carolla, M.D., Denville
George M. Chirovsky, M.D., Dover
Joel M. Gottlieb, M.D., Dover
William A. Hardman, M.D., Morristown
Francis M. Jampol, M.D., Dover
Murray S. Las, M.D., Denville
Kenneth W. Meisner, M.D., Dover
Steven W. Papish, M.D., Morristown
David C. Saypol, M.D., Morristown
Stuart E. Shulruff, M.D., Denville
Kirk E. Sperber, M.D., Oak Ridge
Joseph J. Wallis, M.D., Denville
Richard I. Watson, M.D., Morristown

Ocean County
Wayne R. Draesel, M.D., Toms River
Lawrence A. Gaetano, M.D., Toms River
Alfred E. Palmieri, M.D., Toms River

Passaic County
Manuel Alvarez, M.D., Hoboken
Howard A. Crystal, M.D., Clifton
Lee D. Kaufman, M.D., Pompton Lakes
Jerzy S. Kawecki, M.D., Garfield
Robert M. Klein, M.D., Clifton
Roland A. Lascari, M.D., Pompton Plains
Haroutune A. Mekhjian, M.D., Paterson
Mooriath Ramachandran, M.D., Passaic
Henry Velez, M.D., Paterson

Somerset County
Deborah A. Beiter, M.D., Somerville
Muscu M. Reddy, M.D., Bridgewater

Sussex County
Bartholomew R. D'Ascoli, M.D., Sparta

Union County
Steven J. Berger, M.D., Elizabeth
Desmond E. Smith, M.D., Plainfield
Shekhar T. Venkataraman, M.D., Roselle

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ALCOHOLISM—George W. Miller, Jr., M.D., 77 Grove St., Apt. 8, Montclair, NJ 07042. UMDNJ 1980. Available July 1984.

ALLERGY/IMMUNOLOGY—Leonard Bielory, M.D., 688 Concerto La., Silver Spring, MD 20901. UMDNJ 1980. Board eligible. Solo preferred, but flexible. Available March 1985.

T.M. Bokhari, M.D., 48 Anderson Pkwy., Cedar Grove, NJ 07009. FJMC. Also infectious diseases (pediatric). Board certified (PED). Group, partnership, solo. Available July 1984.

ANESTHESIOLOGY—Cau Pham, M.D., 856 Nelson, Apt. 206, Chicago, IL 60657. Saigon (South Vietnam) 1974. Group or partnership. Available July 1984.

R.S. Saraiya, M.D., 88-25A 153rd St., Apt. 4-F, Jamaica, NY 11432. Baroda (India) 1978. Group or partnership. Available August 1984.

FAMILY MEDICINE—Laurence Levenberg, M.D., 63 Harrowgate Dr., Cherry Hill, NJ 08003. SUNY-Upstate 1966. Group, partnership, solo. Available July 1984.

GASTROENTEROLOGY—Prakash V. Huded, M.D., 80-15 41 Ave., Apt. 606, Elmhurst, NY 11373. Karnatak (India) 1970. Board certified. Solo, group, partnership. Available.

H.L. Kirschenbaum, M.D., 780 Woolley Ave., Staten Island, NY 10314. New York Medical College 1977. Board eligible. Also, internal medicine. Partnership, group, full-time hospital. Available July 1984.

Neil Tarkin, M.D., 6700 192nd St., Fresh Meadows, NY 11365. New York Medical 1978. Also, internal medicine. Board certified (IM). Any type practice. Available July 1984.

Mark F. Tsai, M.D., 1715 Stanford Dr., Columbia, MO 65201. National Taiwan University 1977. Also, internal medicine. Board certified. Available July 1984.

INTERNAL MEDICINE—Z.U.A. Farooqui, M.D., Plaza Professional Bldg., Bayshore Rd. and Greenwood Ave., Box 238, Villas, NJ 08251. Aurangabad Medical College (India) 1972. Board eligible. Group or partnership. Available.

H.L. Kirschenbaum, M.D., 780 Woolley Ave., Staten Island, NY 10314. New York Medical College 1977. Board eligible. Also, gastroenterology. Partnership, group, full-time hospital. Available July 1984.

Quang T. Nguyen, M.D., 15 W. Englewood Ave., Bergenfield, NJ 07621. Saigon (South Vietnam) 1967. Subspecialty, nephrology. Board eligible. Any type practice. Available July 1984.

Claudia Anne Pollet, M.D., 6115 Parkway Dr., Baltimore, MD 21212. Mount Sinai 1981. Board eligible. Salaried position in emergency room, clinic, or urgent care center. Available July 1984.

Richard B. Schwarz, M.D., 8300 De Longpre Ave., Apt. 204, Los Angeles, CA 90069. NYU 1979. Subspecialty nephrology. Board certified. Group, HMO, hospital. Available July 1984.

Gopal Shah, M.D., 100 Caton Ave., Apt. 2-G, Brooklyn, NY 11218. M.R. Medical College (India) 1976. Board eligible. Group. Available July 1984.

Neil Tarkin, M.D., 6700 192nd St., Fresh Meadows, NY 11365. New York Medical 1978. Also, internal medicine. Board certified (IM). Any type practice. Available July 1984.

Mark F. Tsai, M.D., 1715 Stanford Dr., Columbia, MO 65201. National Taiwan University 1977. Also, gastroenterology. Board certified. Available July 1984.

Steven Wolinsky, M.D., 1404 E. 15 St., Brooklyn, NY 11230. Case Western Reserve 1980. Group or partnership. Available July 1984.

NEPHROLOGY—Quang T. Nguyen, M.D., 15 W. Englewood Ave., Bergenfield, NJ 07621. Saigon (South Vietnam) 1967. Also, internal medicine. Board eligible. Any type practice. Available July 1984.

Richard B. Schwarz, M.D., 8300 De Longpre Ave., Apt. 204, Los Angeles, CA 90069. NYU 1979. Also, internal medicine. Board certified (IM). Group, HMO, hospital. Available July 1984.

OBSTETRICS/GYNECOLOGY—Balwant K. Chhatwal, M.D., 6416 Fairfield Ave., Berwyn, IL 60402. Delhi (India) 1975. Group, partnership, solo. Available July 1984.

Sheela Choubey, M.D., 1 Zirkel Ave., Piscataway, NJ 08854. Poona (India) 1977. Board eligible. Group or partnership. Available July 1984.

Edwin R. Guzman, M.D., 1200 E. 98th St., Brooklyn, NY 11236. New York Medical 1980. Board eligible. Group or partnership. Available September 1984.

Atul S. Sheth, M.D., 2951 S. King Dr., Chicago, IL 60616. Specializing in infertility, reproductive endocrinology. Board eligible. Partnership, single or multiple-group practice, academia. Available.

Ernest A. Topran, M.D., 3523 Dewberry-Southern Oaks, Shreveport, LA 71118. Louisiana State 1980. Group or partnership. Available July 1984.

EDIATRICS—Dorothea H. Gross, M.D., 264 Boonton Turnpike, Lincoln Park, NJ 07035. Geneva (Switzerland) 1950. Clinic, group, emergency room, hospital, pharmaceutical research (salaried). Available.

Kusumam Sidharthan, M.D., 222 Yorkshire Ct., Old Bridge, NJ 08857. Calicut Medical College (India) 1976. Board eligible. Available July 1984.

ADIOLOGY/NUCLEAR MEDICINE—Conrad P. Erlich, M.D., 1243 Beacon St., Apt. 3B, Brookline, MA 02146. Boston 1976. Board certified. Group or partnership. Available July 1984.

Mindy M. Horrow, M.D., 131 Pond Brook Rd., Chestnut Hill, MA 02167. Medical College of Pennsylvania 1980. Board eligible. Group, HMO, academia. Available.

Subhash S. Pujara, M.D., Box 391B, Rt. 3, Andalusia, AL 36420. B.J. Medical College (India) 1969. Board certified (radiology); board eligible (nuclear medicine). Group, partnership, solo. Available.

M.S. Vafa, M.D., 10378 Gosport, Apt. 9, St. Louis, MO 63146. Ferdowsi 1973. Also, internal medicine. Board certified. Group or partnership. Available.

URGERY, GENERAL—Sara A. Case, M.D., 284 Quinby Rd., Rochester, NY 14623. Virginia 1975. Board eligible. Group—general surgery in moderate-sized city. Available August 1984.

Ruben J. Delgado, M.D., 7514 Oriental Tr., San Antonio, TX 78244. Puerto Rico 1976. Also, vascular surgery. Board certified. Single or multi-specialty group or solo. Available August 1984.

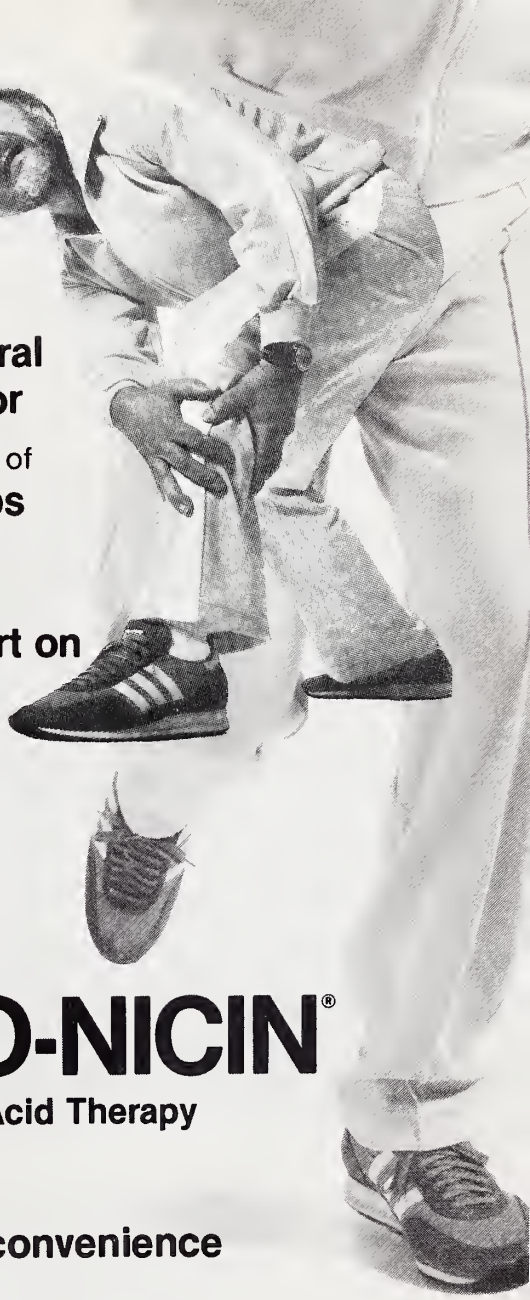
F. Andrew Morfesis, M.D., 7545 Rogers Ave., Upper Darby, PA 19082. Penn State (Hershey) 1979. Board eligible. Available July 1984.

James M. Stern, M.D., 600 Vista Court, Waynesboro, PA 17268. Jefferson 1958. Board certified. Solo, with freedom to practice in broad spectrum of surgery, including vascular and fractures. Available.

URGERY, ORTHOPEDIC—S.N. Saraiya, M.D., 88-125A 153rd St., Apt. 4-F, Jamaica, NY 11432. Baroda (India) 1974. Solo. Available August 1984.

URGERY, VASCULAR—Ruben J. Delgado, M.D., 7514 Oriental Tr., San Antonio, TX 78244. Puerto Rico 1976. Also, general surgery. Board certified (GS). Single or multispecialty group or solo. Available August 1984.

UROLOGY—Kiritkumar M. Pandya, M.D., 950 49th St., Apt. 9-A, Brooklyn, NY 11219. Baroda (India) 1970. Board eligible. Group, partnership, solo. Available.



A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release
LIPO-NICIN®/300 mg.

Each time-release capsule contains:
Nicotinic Acid .....300 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release
LIPO-NICIN®/250 mg.

Each yellow tablet contains:
Nicotinic Acid .....250 mg.
Niacinamide .....75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide .....75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

Likoff Cardiovascular Institute
of
Hahnemann University
offers a course on

CARDIAC IMAGING: UPDATE 1984

- Two-Dimensional Echocardiography
- Doppler Ultrasound
- Radionuclide Imaging
- Newer Techniques

September 6, 7, and 8, 1984
Franklin Plaza Hotel
17th & Vine Streets
Philadelphia, PA 19103

PROGRAM DIRECTORS
Gary S. Mintz, M.D.
Ami S. Iskandrian, M.D.
John P. Panidis, M.D.

Fees
$395.00 for Physicians
$325.00 for Technicians

A full refund will be given if cancellation is received in writing prior to August 1, 1984. A processing fee of $150.00 will be charged for all cancellations received in writing after that time, and no fee will be refunded for "no shows."

Preregistration
Registration is limited and preregistration is suggested and should be made with the attached registration application. Applications should be sent to: Hahnemann University, School of Continuing Education, Broad & Vine, Philadelphia, Pennsylvania 19102. Checks should be made payable to "Hahnemann University."

Registration *(outside Dominion Ballroom)*
Wednesday, September 5, 1984
8:00-10:00 P.M.
Thursday, September 6 through Saturday, September 8, 1984
7:30 A.M. to closing

Meeting Place and Hotel Reservations
The course will be held in the Dominion "D" Ballroom of the Franklin Plaza Hotel, 17th & Vine Streets, Philadelphia, Pennsylvania. Hotel reservations should be made directly with the Franklin Plaza Hotel. A hotel reservation form will be sent to you upon receipt of your application.

For Further Information
Robert J. Schaefer
Director
School of Continuing Education
Hahnemann University
Philadelphia, PA 19102
Telephone: (215) 448-8263

ACCME
Hahnemann University is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing education for physicians.

AMA
As an organization accredited for continuing Medical Education, Hahnemann University certifies that this continuing Medical Education offering meets the criteria for 21 hours in Category I of the Physician's Recognition Award of the American Medical Association, if it is used and compelted as designed.

CARDIAC IMAGING: UPDATE 1984

(please type or print) **SEPTEMBER 6, 7, 8, 1984**

NAME_____

ADDRESS_____ ☐ Office ☐ Home

CITY_____ STATE_____ ZIP_____

SPECIALITY/FIELD OF PRACTICE _____

PHONE _____

Registration Fee:
☐ $395.00 Physicians
☐ $325.00 Technicians
AMOUNT ENCLOSED $_____

Registration Application

Please make check payable to:
HAHNEMANN UNIVERSITY
Mail with application to:
School of Continuing Education
Hahnemann University
Broad & Vine
Philadelphia, Pennsylvania 19102

ME CALENDAR

The following is a list of continuing medical education courses for the next two months. Contact the sponsoring organization for further information.

This list is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the UMDNJ.

NEUROLOGY/PSYCHIATRY

July

2 Behavior Modification
9 1-3 P.M.—Ancora Psychiatric
16 Hospital, Hammonton
23 *(Ancora Psychiatric Hospital and AMNJ)*

5 Basic Neurological Principles for Neuropsychiatrists
12 Significance of Headache in Clinical Psychiatry
19 Treating the Remarried, Those Living Together, and Their Families
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

19 Family and Couple Therapy
12 noon-4:30 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

Aug.

2 Neurological Diagnosis in Psychiatric Syndromes
9 Attention Deficit Disorder
16 The Animal Connection
30 Premenstrual Syndrome—Psychiatric and Medical
12 noon-1 P.M. —Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

OBSTETRICS/GYNECOLOGY

Aug.

15 Drugs, Alcohol, and the Pregnant Woman
8:30 A.M. -3:15 P.M. —Monmouth Medical Center, Long Branch
(Div. of Alcoholism, NJ State Dept. of Health, and AMNJ)

RADIOLOGY

July

2 Basic, Advanced, and Real-Time,
3 Cross-Sectional Sector Scanning
4 9 A.M.-5 P.M.—Sands Hotel,
5 Atlantic City
6 *(The National Foundation for Non-invasive Scanning and AMNJ)*

AN ACT OF LOVE

Their own **DENIAL** that a respected colleague could be **IMPAIRED** and/or the "conspiracy of silence" that makes them unwilling to speak out allows the illness of our impaired colleagues to progress, sometimes to a fatal outcome.

"Blowing the whistle" on a suffering colleague is indeed an **ACT OF LOVE!**

Call Us **EARLY**
We can help **CONFIDENTIALLY**
IMPAIRED PHYSICIANS PROGRAM
(609) 896-1766
Hot Line . . . (609) 896-1884

Seeking new patients?

we are

SPECIALISTS

in

PUBLIC RELATIONS

FOR THE MEDICAL PROFESSION

for a confidential interview call—

(201) 531-7080

phyllis kessel associates

780 West Park Avenue, Oakhurst, N.J. 07755

ACUPUNCTURE IN CLINICAL PRACTICE

N.Y. State Boards of Medicine & Dentistry 25-hour accredited seminar and workshop on the latest theories & techniques of manual and electro-acupuncture, applicable toward the 200-hour requirement for certification, will be given for licensed clinicians (with or without prior training) during the weekend of July 6-8, 1984 and again the weekend of Sept. 9-11, 1984 at the Barbizon Plaza Hotel, New York City. Co-sponsored by the International College of Acupuncture & Electro-Therapeutics, its office journal, Acupuncture & Electro-Therap. Res., Int.J. (published by Pergamon Press and indexed in 15 major indexing periodicals; INDEX MEDICUS, etc.), the Heart Disease Research Foundation and the Neuroscience Dept. of Long Island College Hospital, Pharmacology Dept. of The Chicago Medical School. Also eligible for AMA/CME credit. For information, contact Y. Omura, M.D., ScD., 800 Riverside Drive (8-1), NYC 10032. Tel: (212) 781-6262 or (212) WA8-0658, or Saul Heller, M.D., Tel: (212) 838-7514.

POST-GRADUATE NYU Medical Center MEDICAL SCHOOL

FALL COURSE SCHEDULE

AUGUST	
8/27-8/31	604. Radiation Physics and Biology
OCTOBER	
10/12-10/13	612. Seminar in Ultrasonography
10/13	456. Fine Needle Aspiration of the Prostate Gland
10/15, 17, 22, 24	156. Medical Mycology
10/18-10/21	150. An Eclectic Retrospective: Updated Selections From a Decade of Dermatopathology Symposia at NYU
10/20	550. How to Manage Mental Disorders in General Medical Practice
10/25-10/28	611. Imaging of the Head and Neck (Essex House)
NOVEMBER	
11/17-11/18	734. New Technologies in Urology
11/28-11/30	700. Pitfalls in Surgery
DECEMBER	
12/3-12/6	350. Neurosurgery NYC/1984 (Grand Hyatt Hotel)
12/3-12/7	314. Toxicology and Pharmacology
12/10-12/12	321. Managing Clinical Problems in the Elderly
12/15-12/16	733. Basic Review of Pathology & Radiology for Urologists
12/17-12/22	603. Computed Tomography (Grand Hyatt Hotel)
FOR METROPOLITAN AREA PHYSICIANS	
9/5-3/13	561. Comprehensive Psychiatry: Review & Recent Advances (Wednesdays 8-10pm)
9/5-12/21	400. Basic Sciences in Ophthalmology
9/12-5/22	420. Basic Sciences in Otolaryngology
1/9-6/19	302. Internal Medicine Board Review
FOR INFORMATION	NYU Post-Graduate Medical School 550 First Avenue, New York, NY 10016 (212)340-5295 (24 hr. service)

NEW YORK FERTILITY RESEARCH FOUNDATION, INC.

For the Investigation of Problems of Human Infertility

The Foundation provides a complete diagnostic and consultation service for infertile couples. Investigations are conducted by well-known specialists in conjunction with consultants in the various fields of medicine related to infertility.

The Foundation is supported by an in-house modern laboratory equipped to do most tests required for diagnosis and treatment. Literature on request.

1430 Second Avenue, Suite 103
New York, N.Y. 10021
Phone: (212) 744-5500

,ETTERS TO THE :DITOR

The Medical Director; Baby Doe; Our New Format

'he Medical Director: ınother Opinion

February 16, 1984

ear Doctor Krosnick:

In the August 1983 issue of *The* ɔurnal, you published a letter from r. Charles Harris which could be ıisleading and is in need of clari- cation. In regard to his statement, The next phase in hospital rela- ons is the interpolation of a medi- al director between the adminis- ation and the medical staff," the pinions and issues he raised are ıtelligent and pertinent. However, I m concerned with the reactions of ɔur readers.

Statements such as: "A doctor is nly a doctor when treating patients; erhaps a very good secretary could e trained for the job; our talent is quandered uselessly in nonproduc- ve administrative chores; a medical egree (becomes) subordinate to an dministrative office," seriously are ıisleading. Realistically, what sadly ; lacking is understanding the role of the doctor/administrator. Having been in practice over three decades and a doctor/administrator for over one decade, I emphatically can state that there is "intrinsic beauty" in improving the delivery of health care and the quality of health care through administrative functions. A "good" secretary is a difficult person to define and, of course, could never subsume his role, especially the peer relationships. The medical degree need not become subordinate to an "administrative officer." Either of two relationships commonly prevail. Specifically, there either can be absolute or cooperative control. The physician notifies the administration what policy is best and the lay people try to implement it; or administration suggests a policy or project or procedure to the physician for his professional input which always is respected.

I agree with Dr. Harris that the medical director must react to PRO. PRO monitors utilization—again, realistically the monitor must be monitored. Obviously, with the large sums of money and time spent, carelessness and inefficiency cannot be tolerated. Who will make policy? Who will make the final decisions? Possibly a three-member committee could do the job: the medical director, a representative of the hospital administration, and a representative of the public (either a Chamber of Commerce or labor union individual) who could alternate on a yearly basis. Possibly, an additional member from the local government could be added. The committee would dilute the authority from one person (medical director) to a collective body.

Finally, our profession always has been proud of its moral integrity as a bulwark against the onslaught of economic forces, e.g. an employer paying a salary, the government paying for drugs, medical equipment, and office visits. Already, within our government it is worthy of note that the judicial branch has recognized the pre-eminence of medical ethics in governing physicians' behavior. The Supreme Court of the United States, in a recent decision, stated that physicians employed by the NY State Medicaid Program (Blum *v* Yaretsky, 1982) acted in accordance with the canons of ethics established within their own professional groups, rather than under rules of conduct dictated and imposed by the state. In a discussion of this ruling in the February 24, 1983, issue of the *New England Journal of Medicine* it was pointed out that the court assumed, "That the physicians would act with personal integrity and only on behalf of the best interests of each patient." Let us also assume that the medical director will remain true to the canons of existing professional ethics.

Please understand the above bears no relation to the attitude or opinions of the Division of Medical Assistance in the state of New Jersey. I am writing as an individual and terminating my employment with the Division on March 1, 1984.

(signed) Charles J. Grubin, M.D.

Baby Doe

February 28, 1984

Dear Doctor Krosnick:

I read your excellent dissertation on the Baby Doe controversy in *The Journal* of the Medical Society of New Jersey.

I found it to be very well presented and a reasonable approach to the solution of this difficult problem.

Unfortunately, the lawyers probably won't let us provide a solution as simple and practical as you suggested.

We probably will be using your article as the basis for one of our ethics conferences. I thought you might like some feedback about the article.

(signed) John C. Brogan, M.D.

Our New Format— They Like It

March 18, 1984

Dear Doctor Krosnick:

Just want to congratulate you on the new format of *The Journal.* It is much more readable, clear in the summaries, and generally a fantastic improvement.

Best wishes.

(signed) John A. Sakson, M.D.

March 23, 1984

Dear Doctor Krosnick:

Congratulations on the new format for *The Journal.* It is clean, concise, and very attractive. Best wishes.

(signed) Stanley S. Bergen, Jr., M.D.
President, UMDNJ

The Electrocardiogram in Infants and Children; Evaluation and Decision Making for Health Services Programs; New Frontiers in Mammary Pathology; Fundamentals of Immunology; Progress in Cardiology; Sports Medicine

The Electrocardiogram in Infants and Children: A Systematic Approach

Arthur Garson, Jr., M.D. Philadelphia, PA, Lea & Febiger, 1983. Pp. 421.

In the preface, the author emphasizes the impact the emerging science of electrophysiology has had upon electrocardiography. The first six chapters cover anatomy, physiology, derivation, and definition of the ECG. The middle chapters deal with effects of altered thoracic anatomy, chamber enlargement, interventricular conduction disturbance, and, to a lesser degree, ischemia, injury, and infarction. There is an excellent summary of effects of systemic alterations on the electrocardiogram, e.g. antiarrhythmic drugs, anesthetics, neuromuscular disorders. The latter part of the book is devoted to arrhythmias with emphasis on recognition and etiology when known. Ladder diagrams are used as the major graphic display for analyzing rhythm and conduction variations. Legends for figures tend to be concise with explanations easy to comprehend. The reader is not left to infer the author's intent in a given diagram. Clinical relevance frequently is stressed. The last chapter discusses artifacts which may occur during ECG reading and may lead to errors of interpretation. A method for systematically recognizing artifacts is described.

The appendices are used to summarize important ECG characteristics which vary with age, e.g. PR interval, QRS duration in V_5, R/S ratio in V_6.

The index is well organized and allows rapid location of subjects covered in the text along with designations identifying tables and figures.

A particularly appealing feature to this book is the question-and-answer section following each chapter. The author stimulates the reader to assess his retention of key points. These questions are well selected, clinically relevant, and just as easily could be found on a certifying examination.

This book was very readable. It can be used to teach students of electrocardiography irregardless of background. It also can be an excellent reference text for the journeyman electrocardiographer.

Robert M. MacMillan, M.D.

Evaluation and Decision Making for Health Services Programs

James E. Veney and Arnold D. Kaluzny. Englewood Cliffs, NJ, Prentice-Hall, Inc., 1984. Pp. 302. ($26.95)

For a practicing physician, this book was boring to read, and told me more about "methodological techniques" and "conceptual models" than I cared to know. It defines evaluation as "the collection and analysis of information by various methodological strategies to determine the relevance, progress, efficiency, effectiveness, and impact of program activities." Relevance refers to whether a program is needed. I seriously wonder about the relevance of this book. It probably will find a place in the library of health planners, managers, developers, and statisticians (the ample bibliography lists more articles on econometrics than on health care).

The most interesting is chapter 15, which analyzes cost benefit and cost effectiveness, using the opening of a satellite ambulatory clinic and the addition of a 20-bed pediatric wing to a county hospital as illust tions. The hardest chapter to und stand is chapter 8 because it is full of statistics and meaningle equations. It takes 14 pages to co to the conclusion that "the reduc speed limits nationwide apparen have had some impact on traf deaths on a national basis."

The authors admit that "monit ing, at best, is inconvenient; worst, it uses up time and resourc that providers feel should be devot to 'practice.'" In discussing surv research as an evaluation strate the most interesting illustration the comparison of fee-for-servi group practices with prepaid pra tices: the latter spent 10 to 15 p cent less time serving patients a earned $4,000 to 6,000 less.

Robert Sigmond, one of the ea pioneers in health planning, quoted as saying that hospital pla ning decisions "are not made ov 'hard facts,' they are made over 'ha liquor.'" This book would have be more interesting if it had been wr ten the same way.

John S. Madara, M.

New Frontiers in Mammary Pathology

K.H. Hollmann and J.M. Verl (eds). New York, NY, Plenum Pres 1983. Pp. 455. ($55)

This book represents a record papers presented at the second Sym posium of the International Socie Against Breast Cancer, held in Pari December 7 to 10, 1981. Partic pants were invited guest scientis from Belgium, Brazil, France, Gre Britain, Greece, Italy, Japan, Port gal, Spain, Switzerland, Yugoslavi and the United States.

The supposed causative factors breast cancer were evaluated b specialists; genetic, hormonal, mill factor, (mammary tumor virus) e pecially as studied in mice, are d scribed. The existence of a huma mammary tumor virus could not b demonstrated.

It would appear that mamma carcinogenesis is of multifactor origin and that inherited factors i creasing the susceptibility to brea cancer play an important part. Th existence of cancer genes now i under experimental study. Brea cancer is not a single process bu rather a cascade of events.

Hyperplastic nodules are likely emalignant lesions and represent n important step toward in situ rcinoma and infiltrating cancer. cent efforts in the research field ve focused on: tumor cell markers, rmone receptors, angiogenesis, rostaglandins, thermography, ammography, aspiration cytology, d immune processes.

Digestion of the volume gives one e impression that despite all the ergy that has been devoted to the bject we actually do not know the use of breast cancer in either sex r do we have, as yet, an absolute ethod of therapy.

The book is produced by photo- py methods. The illustrations are ceptable. Printing errors were ted on pages 7, 10, 101, 142, 192, 0, 250 and 257; page 367 the word anel" is misspelled.

Interest in the human breast has isted probably from the days of in and Abel. This volume will con- ue that trend and should be read their progeny.

T. K. Rathmell, M.D.

undamentals of nmunology, 2nd Edition

ientin Myrvik, Ph.D., and Russel Weiser, Ph.D., (eds). Philadelphia, A, Lea & Febiger, 1984. Pp. 510. ustrated. ($24.50)

This attractive hardcover and ll-bound book on the rapidly ex- nding body of knowledge of im- unology truly is remarkable for its ll content and its low price. In ad- tion to two of its editors who also e contributors there are seven ad- tional authors—all but three of om come from the Bowman Gray hool of Medicine in Winston- lem, North Carolina. The other ree authors are from Hamburg, est Germany, University of Geor- a, Athens, Georgia, and the College William and Mary in Gloucester int, Virginia, respectively.

This book is comprised of 25 apters, two appendices, and 14 pages of a very complete index. Chapter 1 is entitled "Introduction to Immunology" and includes history, development, and scope plus terminology; these are interesting and well done. The final chapter is entitled "Immunity to Animal Parasites" and the information is pure 1984. All important subjects in immunology are covered in the intervening chapters. There are many charts and lists and a moderate number of electromicrographs. The latter are very clear and in focus. The chapter on the complement system is superb.

The authors recommend this text for medical and veterinary students. I go beyond this and state it is strongly recommended for pathology and medical residents plus all practicing physicians who want to keep current in this fascinating and very important field.

Hugh F. Luddecke, M.D.

Progress in Cardiology, Volume II

Paul N. Yu, M.D., and John F. Goodwin, M.D., (eds). Philadelphia, PA, Lea & Febiger, 1983. Pp. 195. ($30)

Progress in Cardiology, Volume II contains nine chapters that deal with a variety of cardiovascular problems.

Each chapter is composed and written by groups of distinguished scholars in the field of cardiology. The subjects reported upon are timely and cover most of the methods and laboratory techniques in noninvasive measurements; pulmonary physiology; prostaglandins; hypertension and heart failure relations; the role of catecholamines in hypertensive and congestive cardiomyopathy; pharmacology in pulmonary circulation; relationship between smoking and heart disease; and the pathophysiology and therapy of cardiogenic shock.

A fact this reviewer found very impressive was the agreement among all authors of the direct correlation between cigarette smoking and cardiovascular mortality, morbidity, and the so called "sudden death syndrome" of myocardial infarctions.

The essays, or lectures as they seem, are easy to read and uncomplicated to follow. References are plentiful at the end of each chapter. This text is recommended for all medical libraries and certainly to all cardiologists and family physicians.

Harry M. Poppick, M.D.

Sports Medicine: Health Care for Young Athletes

American Academy of Pediatrics. Evanston, IL, 1983.

Utilizing multiple authors and consultants, this book is a compilation of information concerning all aspects of sports medicine as it pertains to the child and adolescent athletic participant. Each chapter was written by an expert in the field and then reviewed by a panel of consultants to insure accuracy and completeness of information.

Chapters on counseling the family, physical maturation, preparticipation health examination, and assessing athletic potential are particularly useful for the pediatrician and family physician in dealing with the young athlete and his/her family, and advising them regarding participation in various sports best suited for each child, particularly those with specific health problems.

The remainder of the book covers the many health and injury problems encountered in sports participation, and there are chapters on drugs, nutrition, and thermoregulation to include fluid and electrolyte balance.

Printed in paperback fashion, the book has only a few illustrations, but there are many tables, and the book is indexed. Overall, the book is well worth purchasing for reference by any physician dealing with young persons active in sports.

Christine E. Haycock, M.D.

OBITUARIES

Drs. Bochenek; Buckley; Deuell; Frank; Glick; Harrington; Jacobus; Olson; Reich; Rosenberg; Stewart; and Vanderbeek

Dr. Joseph P. Bochenek

On March 17, 1984, a senior member of our Morris County component, Joseph Paul Bochenek, M.D., died at his home. Born in Poland in 1910, Dr. Bochenek received his medical degree from the University of Nancy, France in 1939. Until 1948, he lived in England and served in the British Army as a paratrooper in World War II. Dr. Bochenek emigrated to the United States and set up a practice in family medicine in Netcong. After 20 years he closed his office and served as emergency physician at Dover General Hospital. Dr. Bochenek was a member of the American Medical Association and of the Academy of Emergency Physicians.

Dr. Jeremiah L. Buckley

At the age of 83, Jeremiah Lawrence Buckley, M.D., died on April 17, 1984. Born in 1900, Dr. Buckley received his medical degree from the University of Vermont Medical School in 1926. An internist for 42 years, Dr. Buckley was on the staffs of Saint Barnabas Medical Center, Newark, St. Mary's Hospital, Passaic, and Clara Maass Medical Center, Belleville. He retired in 1968. Dr. Buckley was a member of our Essex County component and of the American Medical Association.

Dr. William D. Deuell

At the age of 74, William D. Deuell, M.D., died on March 31, 1984. Born in Allendale, Dr. Deuell was graduated from Columbia University's College of Physicians and Surgeons in 1934. Prior to his retirement in 1971, he had practiced general medicine in Hackensack for 35 years. Dr. Deuell had been on the staff at Hackensack Medical Center for 32 years. He was a member of the American Medical Association. During World War II, Dr. Deuell served in the medical corps of the United States Navy, attaining the rank of lieutenant commander.

Dr. Perry Frank

We just have learned of the death, on February 9, after a long illness, of Perry Frank, M.D. Born in 1914, and a native of Egg Harbor City, Dr. Frank received his medical degree from the University of Pennsylvania School of Medicine in 1938. Prior to his retirement two years ago because of ill health, he had been a general practitioner in Egg Harbor City for 40 years. During World War II, Dr. Frank served in the medical corps of the United States Navy for five years, attaining the rank of captain. He was a member of the American Medical Association.

Dr. Bernard Glick

A senior member of our Bergen County component, Bernard Glick, M.D., died March 31, 1984, at Passaic General Hospital. Born at the turn of the century in New York City, Dr. Glick received his medical degree from the University of Maryland's School of Medicine in 1927. He was a general practitioner with an office in Lyndhurst until 1970 when he established a practice in Passaic. Dr. Glick had been on the staff at Hackensack Medical Center, Passaic General Hospital, and South Bergen Hospital, Hasbrouck Heights. He was a member of the American Medical Association. During World War II, Dr. Glick served
the medical department of the Arm
of the United States.

Dr. John H. Harrington

At his retirement home in Coc
Beach, Florida, John Henry Ha
rington, M.D., member of our Mor
County component, died on Mar
10, 1984. A native of Buffalo, Ne
York, Dr. Harrington was graduat
from Cornell University's School
Medicine in 1927. He practiced o
stetrics and gynecology in Rockaw
until his retirement in tl
mid-1970s. Dr. Harrington served
the United States Air Force duri
World War II, attaining the rank
major. He was a member of tl
American Medical Association anc
Fellow of the American College
Obstetricians and Gynecologists. D
Harrington was 82 years old at tl
time of his death.

Dr. Raymond E. Jacobus

Word has been received of t
death on January 27 of Raymo
Earl Jacobus, M.D., a member of o
Monmouth County componer
Born in 1920, Dr. Jacobus w
graduated from the School of Mec
cine at Syracuse University in 194
He established a practice in o
stetrics and gynecology in Freeho
and was affiliated with Jersey Sho
Medical Center, Neptune. D
Jacobus was board certified in o
stetrics and gynecology, a Fellow
American College of Obstetricia
and Gynecologists, and a member
the American Medical Associatio

Dr. Vendela E. Olson

Vendela E. Olson (Rucker), M.D.,
member of our Bergen County cor
ponent, died on March 5 at the a
of 78. Dr. Olson was graduated fro
the University of Minnesota's Scho
of Medicine in 1941, and also w
qualified in the field of hospital a
ministration. She was director
medical services at St. Luke's Hosp
tal, New York City, following h
work as an anesthesiologist
Hackensack Hospital. Dr. Olson al
was the first president of the Berge
and Passaic Lung Association uni
following their consolidation, ar
was elected to the American Lur
Association of New Jersey's Hall
Fame in 1982.

r. Samuel B. Reich

At the venerable age of 81, Samuel swell Reich, M.D., a member of our rgen County component, died at s retirement home in Lantana, rida, on April 3, 1984. Born in w York City, Dr. Reich received his edical degree from New York Uni-rsity School of Medicine in 1927, d established a practice in rdiology in Hackensack. He be-me head of the cardiology depart-ent and of the cardiac clinic at rgen Pines County Hospital, Para-us, and was on the staff at Pascack lley Hospital, Westwood, Fair wn Memorial Hospital, and sbrouck Heights Hospital. Dr. ich was a Fellow of the American llege of Physicians and of the erican Geriatrics Society, and o board certified in internal medi-ie. He was a member of the Ameri-n Medical Association and a past esident of the Bergen County edical Society.

Dr. Hyman Rosenberg

Retired since 1974, Hyman Rosenberg, M.D., died in West Palm Beach Florida, on March 1, at the age of 66. A native of Philadelphia, Dr. Rosenberg received his medical degree from Hahnemann Medical College and Hospital, Philadelphia, in 1942. He established a practice in internal medicine in Camden, and was affiliated with West Jersey and Our Lady of Lourdes Hospitals in Camden, and was an instructor at Hahnemann Medical College. Dr. Rosenberg was board certified in his specialty and was a member of the American Medical Association.

Dr. Irving J. Stewart

Born at the turn of the century, Irving Jaggard Stewart, M.D., a member of our Gloucester County component, died on March 19, 1984. A native of Camden, Dr. Stewart was graduated from Jefferson Medical College of Philadelphia in 1925, and the next year established a practice in general medicine in Swedesboro. Aside from 50 years of family practice, he held various municipal offices in his community, serving as police surgeon, school physician, and president of the board of health.

Dr. Stuart W. Vanderbeek

We just have learned of the death on September 9, 1983, of a senior member of the Bergen County component, Stewart W. Vanderbeek, M.D. A native of New Jersey, born in 1895, Dr. Vanderbeek received his medical degree from Jefferson Medical College of Philadelphia in 1921. Prior to his retirement in the mid-1970s, Dr. Vanderbeek practiced general medicine in Englewood, and was an attending at Englewood Hospital. He was a member of the American Medical Association.

Style Sheet

The Journal is the official organ of the Medical Society of New Jersey. The goals of* The Journal *are educational and informational. All material published in* The Journal *is copyrighted by MSNJ.

CONTENT

The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports based on unusual clinical experiences; review articles; clinical notes, succinct items on some aspect or new observation or technique of a case experience; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update; and an opinion column. Editorials are prepared by the Editor and by guest contributors on timely and relevant subjects; editorials are the responsibility of the author. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the Editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made in New Jersey.

ASSIGNMENT OF COPYRIGHT

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978), a transmittal letter or a separate statment accompanying material offered to *The Journal* of the Medical Society of New Jersey must contain the following language and must be signed by all authors:

"In consideration of *The Journal* of the Medical Society of New Jersey taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *The Journal*, MSNJ."

SPECIFICATIONS

Submit two **manuscripts** that must be typewritten and double-spaced on 8½" by 11" paper. Statistical methods used in articles should be identified. Acknowledgements will be made only for specific preparation of an essential part of the manuscript.

Authors are asked to seek clarity, accuracy, and originality; attention to details of grammar, spelling, and typing are important.

The **title page** should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

The author should submit a 40-word **abstract** to be used at the beginning of the article.

Tables must be typewritten and double-spaced on separate 8½" by 11" sheets, with a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source; written permission for r publication from the original pul lisher must be submitted. The co of color photographs must be born by the author.

Generic names should be use with proprietary names indicate parenthetically or as a footnote wi the first use of the generic nam Proprietary names of devices shou be indicated by the registration sy bol—®.

The **summary** of the article shou not exceed 250 words; it should co tain only essential facts.

References should not exceed 3 citations except in review article and should be cited consecutively the text by numbers in parenthes at the end of the sentence. The refe ence list should be typewritten ar double-spaced on separate 8½" l 11" sheets in the numerical order which they are first cited in the te The style of reference is that of *Ind Medicus:*

1. Goldwyn RM: Subcutaneou mastectomy. *J Med Soc N* 74:1050-1052, 1977.

2. Dixon WJ, Massey FJ: *Introdu tion to Statistical Analysis.* Ne York, NY, McGraw-Hill, 1969, p 42-48.

PUBLICATION POLICY

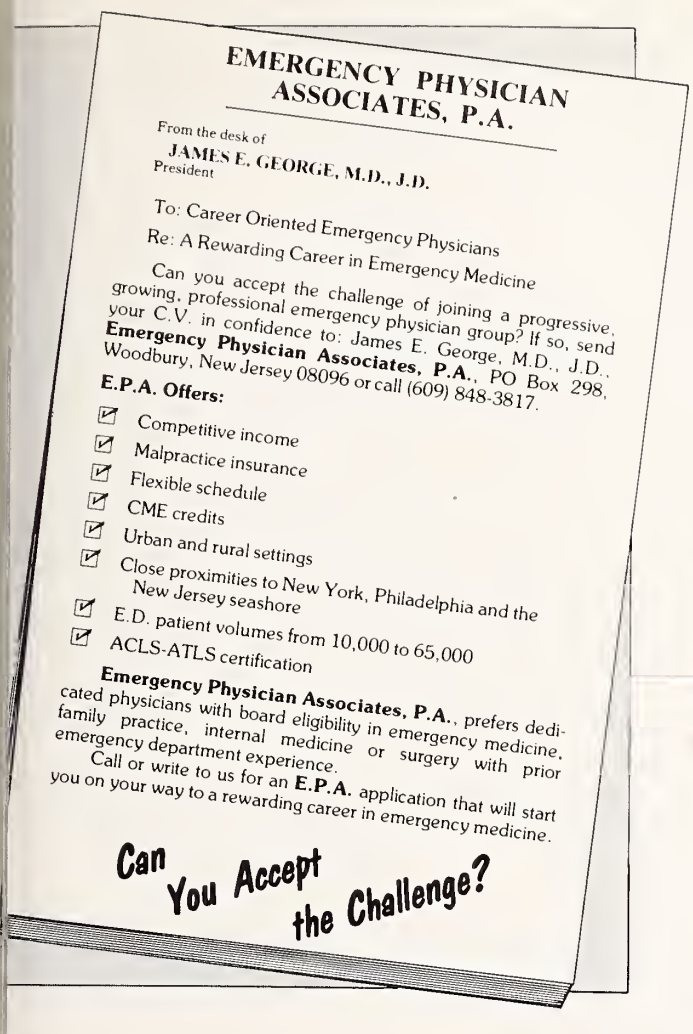
Receipt of each manuscript will b acknowledged and a copy delivere to the Editor who refers the paper t one or more members of the Ed torial Board. The final decision is r served for the Editor. No direct co tact between the reviewers and th authors will be permitted, bu authors will be informed of the r viewers' comments. The publicatio lag for original articles may be s months or more. Galley proofs wi be submitted to the author for co rection of typographical errors.

REPRINT ORDERS

Reprints may be ordered after th author is notified that the artic has been selected for a specific issu of JMSNJ. A check for the cost reprints including remake charge order is received after due date mu accompany the order.

COMMUNICATIONS

All communications should b sent to the Editor, *The Journa* MSNJ, 2 Princess Road, Law renceville, NJ 08648.



EMERGENCY PHYSICIAN ASSOCIATES, P.A.

From the desk of
JAMES E. GEORGE, M.D., J.D.
President

To: Career Oriented Emergency Physicians

Re: A Rewarding Career in Emergency Medicine

Can you accept the challenge of joining a progressive, growing, professional emergency physician group? If so, send your C.V. in confidence to: James E. George, M.D., J.D., **Emergency Physician Associates, P.A.**, PO Box 298, Woodbury, New Jersey 08096 or call (609) 848-3817.

E.P.A. Offers:

- ☑ Competitive income
- ☑ Malpractice insurance
- ☑ Flexible schedule
- ☑ CME credits
- ☑ Urban and rural settings
- ☑ Close proximities to New York, Philadelphia and the New Jersey seashore
- ☑ E.D. patient volumes from 10,000 to 65,000
- ☑ ACLS-ATLS certification

Emergency Physician Associates, P.A., prefers dedicated physicians with board eligibility in emergency medicine, family practice, internal medicine or surgery with prior emergency department experience.

Call or write to us for an **E.P.A.** application that will start you on your way to a rewarding career in emergency medicine.

Can You Accept the Challenge?

GROUP PRACTICE OPPORTUNITIES

BC/BE Family Practitioners for expanding federally qualified HMO, serving 36,000 members from three delivery sites in Cosmopolitan South Jersey area. Congenial staff of 30 full-time physicians, and 75 to 100 contracting specialists covering all disciplines. Excellent hospital facilities. Medical school affiliation. Choice of pleasant living conditions in suburban, rural, or semi-rural communities. Superior schools. Easy access to Philadelphia (15 minutes), New York City (90 minutes), Jersey Shore (60 minutes), Jersey Pine Barrens (20 minutes) and Pocono Recreation Area (2 hours). Competitive salary and comprehensive benefit package.

Send Curriculum Vitae to Kenneth M. Carroll, M.D., Executive Vice President/Medical Affairs, Health Care Plan of New Jersey, 165 Old Marlton Pike, Medford, New Jersey 08055.

Director of Emergency Health Services

Public Health Physician required to direct the statewide activities of an Emergency Health Services unit in the Division of Local and Community Health Services, New Jersey State Department of Health. This position reports to the Assistant Commissioner in charge of the Division and is assigned direct responsibility for the direction and supervision of emergency health services activities including assurance of an effective working relationship with basic life support ambulance services, advanced life support services, law enforcement and public safety agencies, hospital emergency departments and critical care facilities, local health departments, and other community agencies, organizations and individuals.

The Director is charged also with responsibility for assuring that emergency transport facilities meet minimum standards, that certain hospitals are prepared to provide critical care services, that a curriculum is established for the training of health care personnel who are engaged in emergency care (physicians, nurses, paramedics, EMT's, law enforcement personnel); that emergency care is monitored carefully, and that New Jersey's local health departments coordinate their programs with emergency health care services throughout the State.

As one of five doctorate prepared Service Directors in the Division this position has direct access to the Department's senior executive staff. The annual budget totals $1 million. Requirements for this position are graduation from an accredited medical school; a master's degree in public health from a recognized school of public health and seven years of professional experience in public health including at least four years in the management of a statewide or regional community health program preferably with emergency medical services experience and two years of direct clinical experience in emergency medicine. This is an unclassified position with an annual salary range of $41,080.08 to $55,460.60.

Interested candidates should contact:

Dr. Leah Z. Ziskin, M.D., M.S.
Assistant Commissioner
Local & Community Health Services
N.J. State Department of Health
120 So. Stockton Street
CN 364
Trenton, NJ 08625

PAGE REFERENCES

Automobiles ...	445, 467, 468
Computers	441, 464
CME	514, 516
Financial	467, 484-486, 524
Insurance	Cover II, 464, 467
Personnel	523, 524, 525
Public Relations	516
Real Estate	524, 525

The Bottom Line is:

You Supply the Medical Expertise

and we provide

100% Financing For Your FEC.

MEDICAL EQUITIES ASSOCIATES

a marriage of professionals

Our investors will supply the capital for qualified medical professionals to open their free-standing emergency clinic. With NO MONEY DOWN, you can join the trend of innovative doctors who have responded to the public's need for convenient, high quality, and low cost medical care.

THE FUTURE IS IN FEC'S!

Medical Equities Associates will supply you with all you need to own and operate your FEC, including the necessary support systems, real estate, equipment and supplies, building design and management information.

You're aware of the latest medical advances. Be a part of the progressive trend toward free-standing emergency clinics.



Medical Equities Associates

...a marriage of professionals...

609-547-5643

Executive Building, Suite 419
2201 Route 38, Cherry Hill, NJ 08002

Director of Local Health Development Services

The New Jersey State Department of Health has recently undergone an expansion of its local health department interest and funding. A new Division of Local and Community Health Services has been created. This is one of the seven Divisions of the Department which cover Laboratory, Epidemiology, Substance Abuse, Health Facility Development, Administration, and Health Inspection Services.

A Public Health Physician is required to direct the activities of a recently created pivotal unit to be known as Local Health Development Services in the new Division of Local and Community Health Services. Augmented local-state communication services are planned through a combination of ombudsmanship, regular planned meetings, and immediate notification of health emergencies. Consultation and development services are being expanded through liaison of local health agencies with existing Adult, Emergency, Environmental, and Parental and Child Health Services of the Division.

The successful candidate will report to the Assistant Commissioner who heads the Division, and will have direct responsibility for a variety of support services for New Jersey's 117 local health departments. Such support activities include: health aid services in the form of direct local health funding, the development and monitoring of compliance with minimum performance standards, the coordination and maintenance of local health reporting data, and evaluation and training services for local health departments.

This is an extremely critical position with widespread responsibilities for maintaining a partnership between local health departments and the State Health Department. The new unit's annual budget is over $4.5 million.

This position requires a medical degree, a Master's degree in Public Health from an accredited school of public health and seven years of experience in the broad field of public health including at least four years of progressively responsible managerial experience in a regional or statewide public health program. Local health administration experience is desirable. Salary range is from $41,080.08 to $55,460.60, with actual annual salary based on experience and qualifications.

Interested candidates please contact:

Dr. Leah Z. Ziskin, M.D., M.S.
Assistant Commissioner
Local & Community Health Services
N.J. State Department of Health
120 So. Stockton Street
CN 364
Trenton, NJ 08625

CLASSIFIED ADVERTISEMENTS

GENERAL PRACTITIONER—Semi-retired, age 55, desires industrial, pharmaceutical or similar position. 201-445-4339.

GENERAL PRACTITIONER—Experienced general practitioner, M.D. (Paris) 1957. Seeking position in New Jersey—general medicine preferably. Available. John Fredericks, MD, 170-20 Henley Road, Jamaica Estates, NY, NY 11432. Telephone 212-658-1675.

INTERNIST—Board eligible, general internist with extensive emergency room experience. Seeking group practice of internal medicine or emergency room position. Northern NJ area. Available July 1984. please call 212-645-4616, Steven Volinsky, MD. Curriculum vitae and references available upon request.

PEDIATRICIAN—Seeks part time position, Pediatric clinic or office. Middle age, board certified, planning to sell private practice. Prefer Monmouth or Ocean County. Willing to work nights and weekends. Write Box No. 73, JMSNJ.

PHYSICIANS—Registered Dietitian available to provide nutrition, diet and weight-control counseling for your patients in the Trenton-Princeton-New Brunswick area, your office or mine. Call 609-737-2160.

PHYSICIANS REFERRAL—Registered Dietitian available for nutritional counseling, physican referral only. New Brunswick area. Weekend hours and home visits can be arranged. A Healthways provider. 201-257-3773.

NEEDED PHYSICIANS—For successful well known walk-in medical office center, Central NJ. Full and part time, skilled personable American-trained MDs. Send CV to E.V. McGinley, MD, 1005 N. Washington Avenue, Green Brook, NJ 08812.

PRACTICE FOR SALE—General Medicine Practice for sale. Central, NJ, 45 minutes from NY. Blend of office-nursing home patients. Low overhead. Write Box No. 79, JMSNJ.

PRACTICE FOR SALE—Twenty-year old, solo, general practice in South-Central New Jersey. 20 minutes from Philadelphia and 1½ hour from New York City. Busy, efficient, high net. Just negotiated a seven year assignable lease for a new office in the same building. Lovely suburban area with top-rated school systems. A good place to live and work. Leaving to go sailing. Write Box No. 86, JMSNJ.

PRACTICE FOR SALE—OB/GYN, immediately in Northern Monmouth County, near two accredited hospitals, in appealing residential community. Will introduce. Call 201-264-7763.

FOR SALE or RENT—Fully equipped and furnished medical office building including patient's records. Corner location on main street, Kearny, NJ. Call after 8 p.m. 201-746-1709.

FOR SALE or RENT—For immediate occupancy new, modern, energy efficient rental 500 to 2,000 square feet available. 31,000 residents within three mile radius. Close to Philadelphia, Atlantic City; in Central New Jersey shore area. Internists and specialities needed. Ideal for main/satellite office. Call 201-350-1008.

FOR SALE—Equipment. Blue examining table, White instrument cabinet, Four attached Black chairs and table, Doctor's walnut desk, Miscellaneous. Please call 991-6250 or 435-4209.

FOR SALE—Country Estate. For Great living or investment. 74 acres Catskills, 100 miles from NYC. Magnificent view. 9-room house, large living room with fireplace, dining room, 4 bedrooms, 3 baths, superb kitchen with Jenair and microwave. Playroom, large storage cellar, 4 room guest cottage, 4 room guest house, 4 car garage, large barn, trout pond, bass, skiing, snowmobiling, deer, wild turkey, white water canoeing nearby. $250,000 antiques and furnishings may be separately negotiated only with estate purchase. Isabell Sander 914-482-5191.

FOR LEASE—Attractive, modern medical building, Morris Avenue, Union Center, Union, NJ. Office for lease. 750 square feet, large, private adjoining parking lot, 1st floor, no steps . . . will build to suit. Phone 201-688-2480.

OFFICE SPACE—Professional office for rent. Approximately 710 square feet. Near Dover General Hospital, near Routes 80 and 46. Morris County, NJ. Telephone 201-366-2557.

OFFICE SPACE—Professional office space for rent. Millburn prestigious building. 775 square feet, on-site parking, on bus route. Call 201-731-1900.

OFFICE FOR RENT—Professional office for rent, furnished, located in the Ironbound Section of Newark. Available July 1984. Call 201-762-6781.

OFFICE SPACE NEEDED—Licensed Clinical Psychologist with child, adolescent, and adult practice would like to rent office space in the Madison, Florham Park, or Morristown area. Must have own office. Professional building preferable. Please leave message at 201-267-4997 or write to: Merrilea Brunell, Ph.D., 21 Mt. Kemble Ave., Morristown, NJ 07960.

OFFICE TO SUBLET—Medical office to sublet in professional building in Deptford (Woodbury) area. 609-853-8720.

OFFICE TO SHARE—Bergenfield, centrally located professional building. Parking, furnished, 900 square feet, $450. Five minutes from hospitals. Summer 1984. Write or Call Ronny Meier, MD, 297 S. Washington Ave., Bergenfield, NJ 07621. Phone: 201-385-8350.

OFFICE TO SHARE—Central Denville, in recently renovated medical building. Furnished, equipped, utilites included. Ample parking, public transportation. For information: 201-625-9411.

OFFICE TO SHARE/RENT—Spacious, furnished 600-1500 square feet, ample parking. Hazlet-Holmdel area, close to hospital. Call 201-264-7763.

OFFICE TO SHARE/RENT—At two locations in Hudson County. Furnished, parking, close to hospitals and transportation, all utilites included. 201-864-7172.

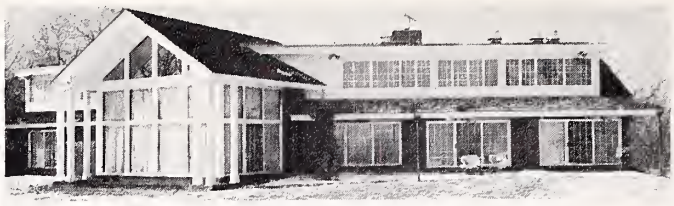
OFFICE TO SHARE—Morristown, central location. Near hospital, fully equipped, newly decorated. All utilities included. Ample parking available. Near public transportation. Available immediately 201-267-2555.

OFFICE TO SHARE—Westfield, central location, near hospital, fully equipped, attractively decorated. All utilities included. Ample parking available. Near public transportation. Available immediately 201-267-2555.

VACATION—Martha's Vineyard, Mass. 3 bedroom house, free tennis, fresh and salt ponds. Available for rent by week, month or season. For information call 201-625-9411.

AUTUMN FOLIAGE—Photography seminar at a country inn, Northern Vermont, September 19-24, 1984. CME credit. Call or write: John L. Krause, Jr., MD, South Jersey Medical Center, Cherry Hill, NJ 08034. 609-795-7766.

RATE INFORMATION FOR MEMBERS: $5.00 per insertion up to 25 words; 10 cents each additional word. Payable in advance. **WORD COUNT:** Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one word, and "Write Box No. 000, c/o JMSNJ" as six words. **COPY DEADLINE:** Fifth of preceding month.



Specially designed home faces N.Y.C. skyline

Cedar Grove, N.J.

This 17 year old address offers many intrinsic valuable intangibles. Set high on a bluff, an unparalleled ultra spectacular New York City Skyline (12 mi. distant) unfolds in never ending viewing thrills. 17 rooms (5 bedrooms) 10 baths, Cathedral living room, 24 x 40 game room, Norwegian sauna, 35 foot Jacuzzi health pool, huge outdoor swimming pool with children's wading pool, two and one half acre plot includes subdivided plot and a host of other must see features. Widow must sell at a drastically reduced price which is half of the reproduction cost $675,000. Private low interest financing. Brokers invited.

Savino Agency—251 Ridge Rd., Lyndhurst, N.J. 201-438-3120

TWO MEDICAL SUITES

Available August—Livingston Avenue (Doctors' Row)—New Brunswick, NJ. Both suites fully carpeted, sink, closets in each room. One suite has X-Ray room with equipment.

For Information Please Call
201-828-2715

DOCTORS!

We need your service to complete a brand-new, elegant, boutique-style shopping and office center. Several medical offices within center. Great location in upscale, affluent, growing area. Just 5 miles from both Middlesex General University Hospital and St. Peters Medical Center. Hidden Lake Towne Center, Off Rt. 27, No. Brunswick.

For Information Please Call
(201) 846-5700

Need A Temporary Physician?

CompHealth treats your practice as if it were our own during: vacations, CMEs, recruiting, clinic start-up or other absences.

Want Free Time While You Practice Medicine?

Join CompHealth's Locum Tenens Physician Group.

★

For further information about temporary coverage or locum tenens practice opportunities, call:

CompHealth
A Physician Group

WILSON ROSS, Regional Administrator
244 East Hanover St.
Trenton, NJ 08608
Telephone: 609-392-1111

ADVERTISEMENT

Multi-specialty Surgical Group in New Jersey has opportunities for: Vascular surgeon, urologist, orthopedist, pediatric surgeon, head and neck surgeon. Must have or be eligible for New Jersey license. All operating expenses paid. Write to New Jersey Physician Placement Service, Box 252, Fair Lawn, New Jersey 07410.

SPECIALISTS WANTED IN PERU

Pediatricians—Gynecologists—General Surgeons to spend two or three weeks in Peru teaching and working with local specialists. Must know some Spanish. Room, board and gratitude provided. Pay own airfare. Write:

PROJECT PERU, INC.
c/o Robert Zufall, M.D.
64 Baker Ave.
Dover, N.J. 07801

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

JULY 1984



LIBRARY
U.C. SAN FRANCISCO
AUG 2 1984

MERCER OAK

the Library
division

Send this coupon for no-obligation information of the savings under the Medical Society of New Jersey Endorsed Insurance Plans

Check this list against your coverages . . . .

- ☐ $5000 Monthly Guaranteed Convertible Accident and Health
- ☐ $10,000 Monthly Practice Overhead Expense
- ☐ $1,250,000 Term Life Insurance
- ☐ $500 Deductible COMPREHENSIVE MILLION-DOLLAR MAJOR MEDICAL PLAN—No other coverage needed—Issuable to Age 69
- ☐ $15,000 Deductible MILLION-DOLLAR UMBRELLA MAJOR MEDICAL PLAN for holders of Blue Cross and other Major Medical Plans—Issuable to Age 69
- ☐ $100-a-day Hospital Income Policy
- ☐ $200,000 High Limit Accident Plan
- ☐ Keogh and Corporate Plan NOW! $15,000 KEOGH

E. & W. Blanksteen Agency, Inc.

E. & W. Blanksteen
75 Montgomery St.,
Jersey City, N.J. 07302
(201) 333-4340
or (800) 742-2849

Name: _____

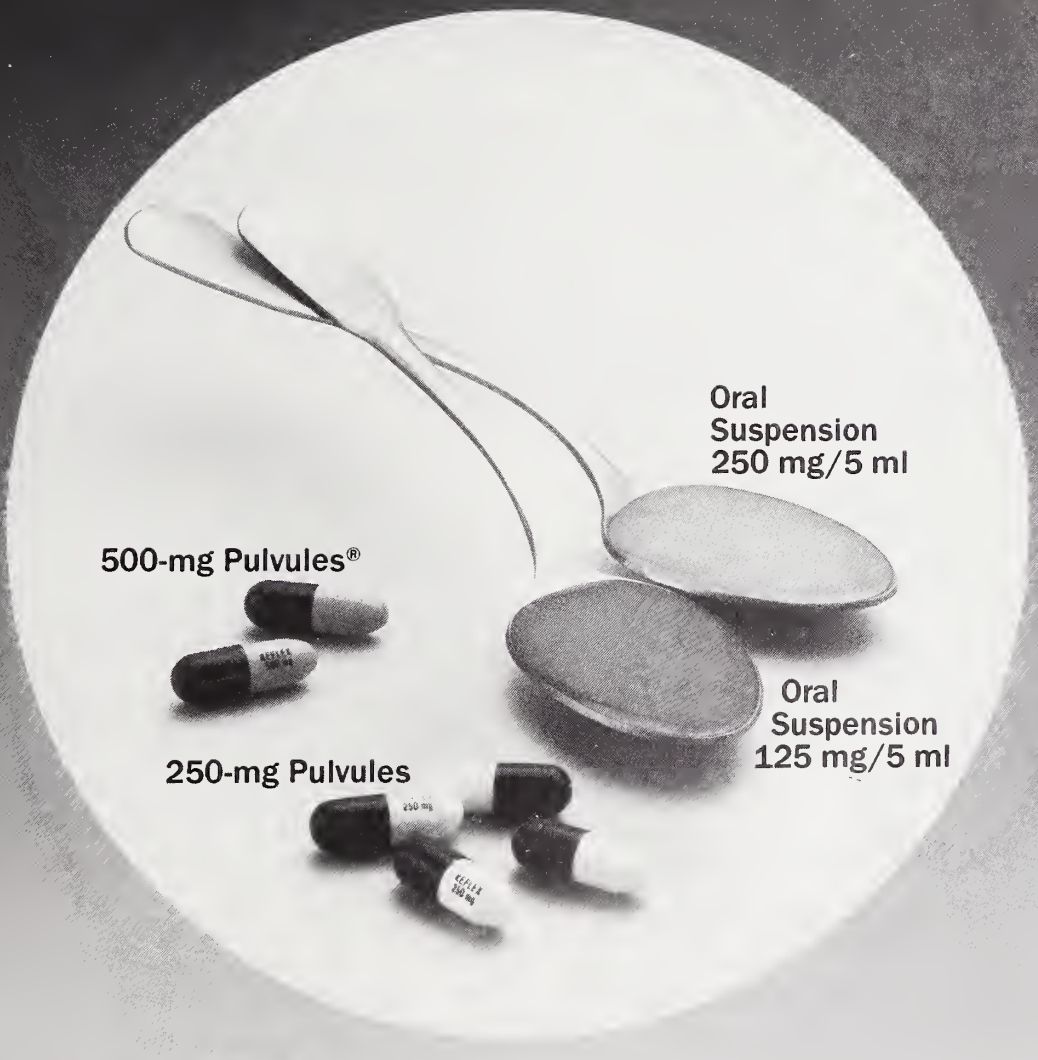
Address: _____

_____

Tel. No. _____

Best Time To Call _____

Easy To Take



Keflex®
cephalexin

Additional information
available to the profession
on request.

DISTA
420113

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

Officers and Trustees

PRESIDENT AND CHAIRMAN OF THE BOARD
Frank Y. Watson, M.D. (Essex) ..... Glen Ridge
PRESIDENT-ELECT
Ralph J. Fioretti, M.D. (Bergen) ..... Rochelle Park
FIRST VICE-PRESIDENT
Edward A. Schauer, M.D. (Monmouth) ..... Farmingdale
SECOND VICE-PRESIDENT
Harry M. Carnes, M.D. (Camden) ..... Audubon
IMMEDIATE PAST-PRESIDENT
Alexander D. Kovacs, M.D. (Union) ..... Scotch Plains
SECRETARY
Arthur Bernstein, M.D. (Essex) ..... South Orange
TREASURER
Paul J. Hirsch, M.D. (Somerset) ..... Bridgewater

Trustees

Joel S. Cherashore, M.D. (1986) (Essex) ..... Nutley
Douglas M. Costabile, M.D. (1987) (Union) ..... Murray Hill
Palma E. Formica, M.D. (1987)
(Middlesex) ..... New Brunswick
Harry W. Fullerton, Jr., M.D. (1985)
(Salem) ..... Carney's Point
Frank Gingerelli, M.D. (1986) (Bergen) ..... Hackensack
Michael M. Heeg, M.D. (1987) (Mercer) ..... Trenton
Louis L. Keeler, M.D. (1985) (Camden) ..... Collingswood
John P. Kengeter, M.D. (1987) (Ocean) ..... Toms River
Edwin W. Messey, M.D. (1985) (Burlington) ..... Willingboro
Myles C. Morrison, Jr., M.D. (1985) (Morris) .... Morristown
John J. Pastore, M.D. (1986) (Cumberland) ..... Vineland
Carl Restivo, Jr., M.D. (1987) (Hudson) ..... Jersey City
Bernard Robins, M.D. (1987) (Essex) ..... Springfield
Gerald H. Rozan, M.D. (1987) (Passaic) ..... Wayne

Councilors

FIRST DISTRICT
(Essex, Morris, Union, and Warren Counties)
Edward M. Coe, M.D. (1987) ..... Cranford
SECOND DISTRICT
(Bergen, Hudson, Passaic, and Sussex Counties)
Robert A. Weinstein, M.D. (1986) ..... Newton
THIRD DISTRICT
(Hunterdon, Mercer, Middlesex, and Somerset Counties)
Louis G. Fares, M.D. (1985) ..... Trenton
FOURTH DISTRICT
(Burlington, Camden, Monmouth, and Ocean Counties)
Frederick W. Durham, M.D. (1987) ..... Haddonfield
FIFTH DISTRICT
(Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties)
Paul H. Steel, M.D. (1986) ..... Atlantic City

AMA Delegates

William J. D'Elia, M.D., *Chairman* (1985) ..... Spring Lake
Alfred A. Alessi, M.D. (1986) ..... Hackensack
Frederick W. Durham, M.D. (1986) ..... Haddonfield
Palma E. Formica, M.D. (1986) ..... New Brunswick
Karl T. Franzoni, M.D. (1986) ..... Trenton
John S. Madara, M.D. (1986) ..... Salem
Henry J. Mineur, M.D. (1986) ..... Cranford
Myles C. Morrison, Jr., M.D. (1985) ..... Morristown
Howard D. Slobodien, M.D. (1985) ..... Metuchen

AMA Trustee

James S. Todd, M.D. (Ridgewood) ..... Bergen

July 1984

Publication Committee

Paul J. Hirsch, M.D., *Chairman*
Dirck L. Brendlinger, M.D.
Frederick B. Cohen, M.D.
A. Olusegun Fayemi, M.D.
Robert M. MacMillan, M.D.
Leon G. Smith, M.D.
La Verne Fioretti

Editor

Arthur Krosnick, M.D.

Managing Editor

Geraldine R. Hutner

Assistant Managing Editor

Dorothy J. Griffith

Advertising Manager

E. Elizabeth Cookson

Executive Director

Vincent A. Maressa

Executive Director Emeritus

Richard I. Nevin

Editorial Board

Jerome Abrams, M.D. (Obstet/Gynecol)
Joseph Alpert, M.D. (Vasc Surg)
Harold Arlen, M.D. (Otolaryngol)
Alfonse Cinotti, M.D. (Ophthalmol)
Robert Dodelson, M.D. (Nephrol)
Norman H. Ertel, M.D. (Int Med/Endocrinol)
Daniel P. Greenfield, M.D. (Psychiat)
Christine E. Haycock, M.D. (Sports Med)
Monroe S. Karetzky, M.D. (Pulmon Med)
Avrum L. Katcher, M.D. (Pediatr)
Stanley C. Leonberg, Jr., M.D. (Neurol)
Joel D. Levinson, M.D. (Gastroenterol)
Joseph A. Lieberman, III, M.D. (Fam Med)
Henry R. Liss, M.D. (Neurosurg)
Geobel A. Marin, M.D. (Int Med/Gastroenterol)
Donald G. McKaba, M.D. (Allergy)
Robby Meijer, M.D. (Plas Surg)
Frank T. Padberg, Jr., M.D. (Surg)
Christopher A. Papa, M.D. (Dermatol)
Norman Riegel, M.D. (Book Review)
Edwin L. Rothfield, M.D. (Cardiol)
Benjamin F. Rush, Jr., M.D. (Surg)
Morris H. Saffron, M.D. (Med His)
Mark M. Singer, M.D. (Int Med/Endocrinol)
Sheldon D. Solomon, M.D. (Rheum)
Lloyd N. Spindell, M.D. (Radiol)
A. Arthur Sugerman, M.D. (Psychiat)
Stephen F. Wang, M.D. (Pediatr)
Edwin S. Wilson, M.D. (Radiol)
Louis S. Zeiger, M.D. (Nucl Med)
Robert B. Zufall, M.D. (Urol)

The Journal of the Medical Society of New Jersey (ISSN-0025-7524) is published monthly (since 1904) except semimonthly in July (13 issues), under direction of the Committee on Publication, by the Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648. Printed in East Stroudsburg, PA, by the Hughes Printing Co. Whole number of issues 964. Member's subscription ($10) is included in Society dues. Rates for nonmembers $20; outside USA add $7.50 for postage. Single copies, $2. Address communications to *The Journal* MSNJ, Two Princess Road, Lawrenceville, NJ 08648, (609) 896-1766. Second-class postage paid at Trenton, NJ, and additional entry office.

Copyright 1984 by the Medical Society of New Jersey.

Find your doctor is the headline in what has to be one of the largest posters ever produced—three feet by five.

This poster is in fact a directory of the approximately 10,000 Participating P.A.C.E. Physicians and Providers.

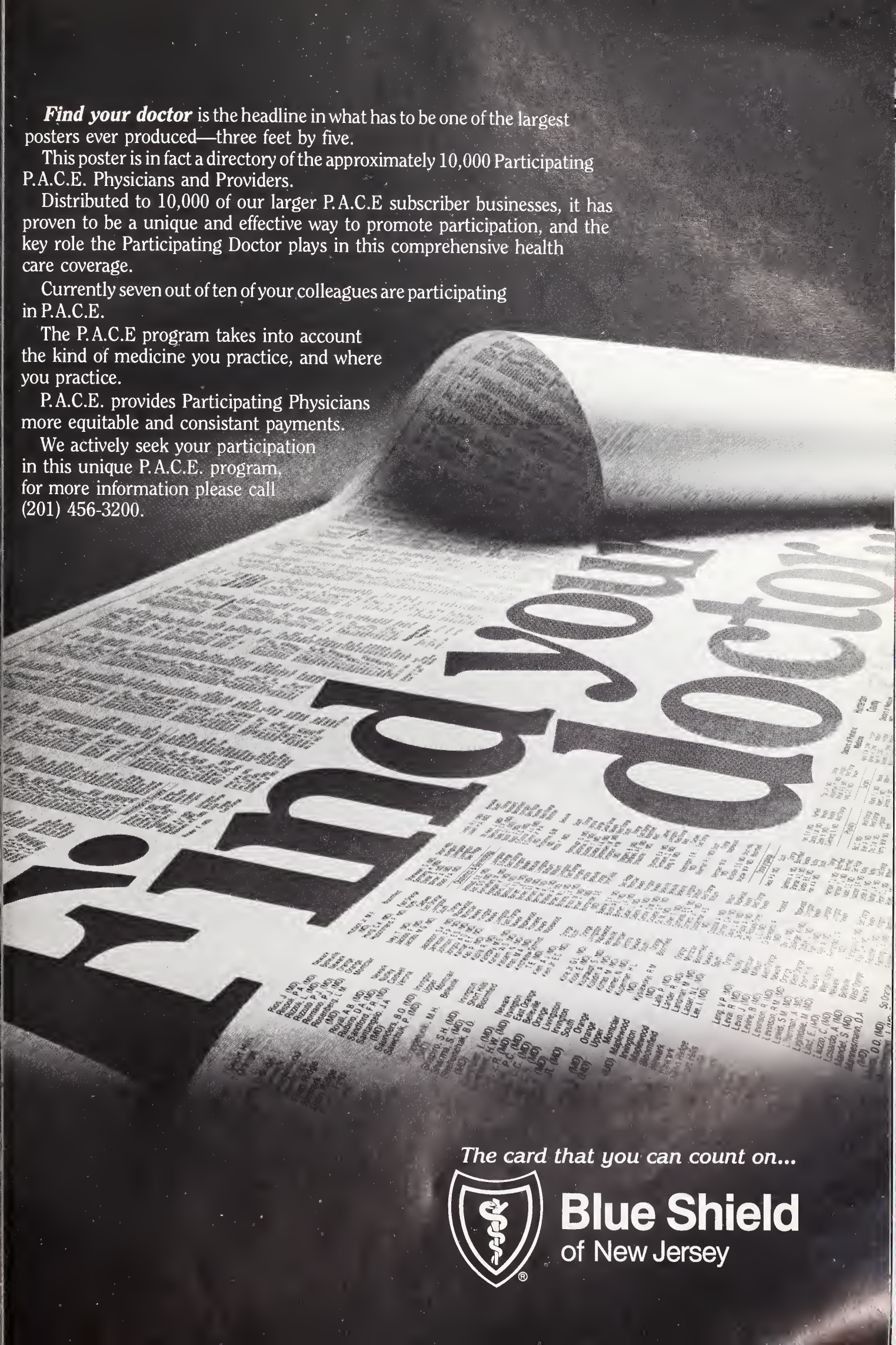
Distributed to 10,000 of our larger P.A.C.E subscriber businesses, it has proven to be a unique and effective way to promote participation, and the key role the Participating Doctor plays in this comprehensive health care coverage.

Currently seven out of ten of your colleagues are participating in P.A.C.E.

The P.A.C.E program takes into account the kind of medicine you practice, and where you practice.

P.A.C.E. provides Participating Physicians more equitable and consistant payments.

We actively seek your participation in this unique P.A.C.E. program, for more information please call (201) 456-3200.



The card that you can count on...

Blue Shield
of New Jersey

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

JULY 1984

FEATURES

532 Membership Newsletter
537 Professional Liability Commentary
541 Editorial Special: The Academy of Medicine of New Jersey Awards
543 Editorial
545 Hospital Governing Boards

CONTRIBUTIONS

549 Out-of-Hospital Births: A Survey of Parents
M. Gregory, M.D., R.B. McDonough, R.N., L. Maciorowski, R.N., E. Miller, M.S., Trenton
557 Case Report: Alcoholic Cardiomyopathy
I.A. Gáspár, M.D., Englewood
563 Case Report: Tracheoesophageal Fistula and Arteriosclerotic Aortic Aneurysm
R. Schiffman, M.D., Camden
569 Clinical Note: Guided Blind Endotracheal Intubation
J.J. Choi, M.D., M. Potian, M.D., E.Y. Yoo, M.D., W. Wu, M.D., Newark
573 Clinical Note: Adverse Drug Reaction after Administration of Influenza Vaccine
R. Solomon, M.D., J. Morlino, D.O., M. Martucci, R.N., D. Ney, R.N., Union
576 Medical History: Conversations in Medicine
A. Weisse, M.D., Newark
581 Current Nutrition: Progress in Food Allergy and Food Sensitivity
R.N. Podell, M.D., New Providence
586 JEMPAC Update
W.E. Ryan, M.D., Pennington

DOCTORS' NOTEBOOK

589 Trustees' Minutes: May 2, 1984, and May 6, 1984
590 UMDNJ Notes, Stanley S. Bergen, Jr., M.D.
591 Practical Solutions to Common Transfusion Problems
594 Physicians Seeking Location in New Jersey

MSNJ DEPARTMENTS

597 CME Calendar and Information
604 Letters to the Editor
605 Book Reviews
607 Obituaries
608 Information for Authors

On the Cover: Attendees at AMNJ's Awards Dinner received an original limited edition print by Richard Kemble which is a semi-abstract impression of the oak tree on Princeton Battlefield. Kemble was inspired by Japanese calligraphy.



The RCA solution for paperwork headaches.

Introducing the cure to all your administrative headaches. The Medical Management System from RCA. This unique system was designed by a physician for physicians. It handles everything from insurance claims and patient billing to invoice tracking and cash disbursements. It takes the hassle out of time-consuming billing procedures and gives you greater control of the business side of your practice.

You'll feel good about the RCA Medical Management System when you see the price, too. It's affordable. Easy to use. And includes an IBM personal computer, a high-capacity disc storage unit, a printer, and the RCA Medical Management software.

We'll take care of everything — delivery, installation and user training. And the entire system is backed by RCA's one-year, on-site service warranty.

Make an appointment today to see a special demonstration of the RCA Medical Management System. Just call collect **(609) 338-4129** and let RCA help make your practice perfect.

RCA Data Services



MEMBERSHIP NEWSLETTER

M
S
N
J

THE MEDICAL SOCIETY OF NEW JERSEY VOLUME 1

DRGs AS AN AUDIT TOOL

There has been considerable debate on the effectiveness of DRGs as a reimbursement methodology. At a Washington meeting of the American Society of Anesthesiologists (May 1984), spokesmen from the Senate Finance Committee and the Health Care Financing Administration indicated that it is impossible to establish that the DRG method of reimbursement is an effective method of controlling the cost of hospital care.

A recent report published in *Health Care Notes* (Ernst and Whinney, No. J58514) concludes that DRG analysis of physician performance can be incomplete and lead to an improper conclusion. A cardiologist at a midwest hospital was producing a length of stay and charges for his patients by DRG which were consistently higher than those of his peers. The hospital decided to investigate further, using disease staging techniques which incorporate severity of illness into the analysis. It then was found that the physician was treating the cases of greatest severity within each DRG. It was concluded that this practice pattern actually was quite efficient.

Disease staging is more effective for audit since, unlike DRGs, it focuses directly on the severity of a patient's illness. It, therefore, provides meaningful information and allows comparisons of treatment superior to that done by DRG.

Ernst and Whinney suggest that hospital administrators should consider using disease staging to gain a better understanding of treatment patterns before attempting to influence physician practices.

AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS–STATE OF NEW JERSEY, INC.

The American Association of Medical Assistants–State of New Jersey, Inc., is an outstanding professional organization, dedicated to the education and self-improvement of medical assistants. It has mai tained strong and effective liaison with the Medic Society of New Jersey and has been a constant, abl and devoted ally of the medical profession.

The House of Delegates of the Medical Society of Ne Jersey voted to support the American Association Medical Assistants–State of New Jersey in the hop that this fine organization will continue to grow.

PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

In a letter to the House and Senate Appropriatio Committees, the AMA supported the full budget ap propriation request for the Prospective Paymer Assessment Commission (ProPAC). The AMA state that, "If ProPAC is not afforded adequate funding, w are concerned that it will be incapable of makin reasoned recommendations to the Secretary of the D partment of Health and Human Services (HHS), an that Medicare beneficiaries could suffer if the prospe tive payment system flounders and hospitals are force to curtail services or even close their doors."

MEDICARE AND MEDICAID REIMBURSEMENT OF PRACTITIONERS WHO LOSE A LICENSE IN ONE JURISDICTION AND RELOCATE TO ANOTHER

The AMA expressed concern that health care pract tioners who have been found unfit to practice in on jurisdiction can relocate and practice in anoth jurisdiction where they are licensed. The witne stated that since the AMA Masterfile appears to be th only source of multistate licensing information o physicians, the AMA now will notify the medic licensure boards when it receives verifiable info mation concerning license revocation, suspension, c surrender for cause involving physician competenc Also, AMA's model state discipline legislation will b updated to include suspension, revocation, or su

nder of a medical license for competency-related use in another state as grounds for disciplinary ac-)n. The AMA stated that it would support a legislative oposal to close gaps in the federal government's ithority to exclude a sanctioned practitioner from edicare and Medicaid participation regardless of ensure status in other states.

)NVENTION MANAGER

Ms. Eileen Pfeiffer has been made the manager of SNJ's Annual Meeting Convention. We congratulate s. Pfeiffer on her new position and her fine per-rmance as manager of the 218th Annual Meeting at sorts International Hotel and Casino, Atlantic City.

)LICY STATEMENTS: NURSING PROCEDURES EW JERSEY BOARD OF NURSING

(1) Irrigation of Frontal Sinuses: It is the con-dered opinion of the Board, that in accordance with J.A.C. 45:11-23 et seq., irrigation of frontal sinuses)uld be an inappropriate function of a registered ofessional nurse.

(2) Intracranial Pressure Monitoring: It is the con-dered opinion of the Board that according to N.J.S.A. :11-23: a) injection of fluid into the cranial cavity; removal of cerebral spinal fluid from an intraven-cular monitoring catheter; and c) the inclusion of a ntinuous flush device in the intracranial pressure ie is beyond the scope of professional nursing prac-e.

(3) Instillation of Local Anesthetic during Flexible onchoscopy: It is the considered opinion of the)ard that according to N.J.S.A. 45:11-23, it is beyond e scope of practice for a licensed practical nurse to still lidocaine or other local anesthetic through the onchoscope.

(4) Instillation of Renagrafin 60: It is the con-dered opinion of the Board that according to N.J.S.A. :11-23, it is beyond the scope of practice for a ensed practical nurse to instill renagrafin 60 into a theter during an endoscopic retrograde cholan-)pancreatography.

(5) Administration of Intravenous Medications rough a Heparin Lock by Students in Professional hools of Nursing: It is the considered opinion of the)ard that students in professional schools of nursing ay with direct supervision hang intravenous "piggy-ck" medications which are administered through a parin lock. The student may flush the heparin lock th heparinized solution before and after the medi-tion has been administered according to estab-hed hospital policy.

MEDICAL HELP FOR TRAVELERS ABROAD

If you are traveling abroad this year, you might wish to consider signing up with HEALTH CARE ABROAD, 923 Investment Building, 1511 K Street N.W., Washington, DC 20005. Telephone: (202) 393-5500. Thc company provides a listing of English-speaking doctors in most major cities abroad (with phone numbers) and, for $2.50 a day during the trip, would pay your medical and hospital expenses in any country, as well as for special travel arrangements should you become unable to fly home in the normal way.

DRG VALIDATION/CERTIFICATION

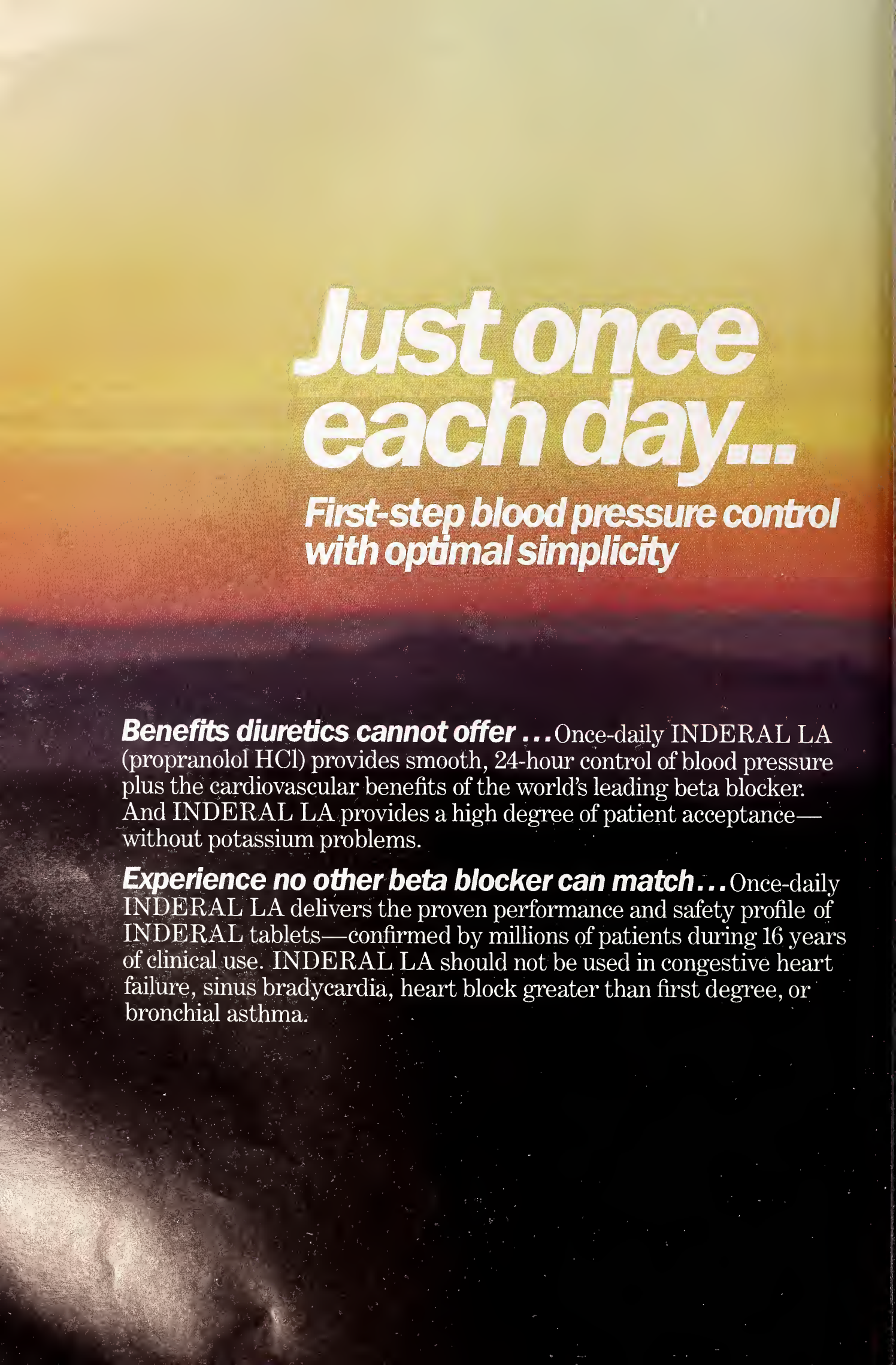
The AMA commented on the requirement in the final regulations on the Medicare prospective payment regulations mandating that the attending physician validate and certify the primary and secondary diagnosis and procedures performed to allow the review entity to ascertain the validity of the DRG, and as a condition for payment to the hospital by Medicare. In objecting to this requirement, the AMA stated that it created confusion about exactly what is to be certified; terms were undefined; and that it is both offensive and unnecessary. The Association went on to say that, "Because of the questionable value and need for certification as now required and because of serious concerns about what the physician is expected to certify, we need to explore the need and rationale of DRG physician certification and whether this regulation can be withdrawn."

HOSPITAL MANAGEMENT OF INJURIES ARISING FROM EXPOSURE TO OR INVOLVING IONIZING RADIATION

The "Guide to the Hospital Management of Injuries Arising from Exposure to or Involving Ionizing Radiation" was prepared by the AMA's Department of Environmental and Occupational Health Programs in response to a resolution adopted by the House of Delegates. The report presents a set of guidelines that can be used by hospital staffs for the initial care of persons receiving accidental exposures to ionizing radiation or becoming contaminated with radioisotopes. Single copies of the report can be purchased for $6.00 plus $3.50 for shipping and handling. All order inquiries should be addressed to: Order Department—OP 35, American Medical Association, P.O. Box 10946, Chicago, IL 60610.

FINI

Never let yesterday use up today.


Just once each day...
First-step blood pressure control with optimal simplicity
Benefits diuretics cannot offer . . . Once-daily INDERAL LA (propranolol HCl) provides smooth, 24-hour control of blood pressure plus the cardiovascular benefits of the world's leading beta blocker. And INDERAL LA provides a high degree of patient acceptance—without potassium problems.
Experience no other beta blocker can match . . . Once-daily INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.



Start with 80 mg once daily... Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



80 mg 120 mg 160 mg

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

Just once each day for initial therapy in hypertension.

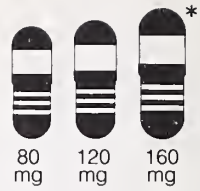
Ayerst®

Just once each day for initial therapy in HYPERTENSION.

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.
INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.
INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.
The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.
In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.
In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.
The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the platelets of the brain.
Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.
Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.
Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.
Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.
Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.
IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking the prior to major surgery is controversial. It should be noted, however, that the impaired abil the heart to respond to reflex adrenergic stimuli may augment the risks of general anesth and surgical procedures.
INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of t receptor agonists and its effects can be reversed by administration of such agents, dobutamine or isoproterenol. However, such patients may be subject to protracted se hypotension. Difficulty in starting and maintaining the heartbeat has also been reported beta blockers.
DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the pearance of certain premonitory signs and symptoms (pulse rate and pressure change acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be difficult to adjust the dosage of insulin.
THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroic Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symp of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function t
IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have b reported in which, after propranolol, the tachycardia was replaced by a severe bradyca requiring a demand pacemaker. In one case this resulted after an initial dose of 5 propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impa hepatic or renal function. INDERAL is not indicated for the treatment of hyperter emergencies.
Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Pat should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal lead to a return of increased intraocular pressure.
Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart dise elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.
DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as r pine should be closely observed if INDERAL is administered. The added catecholan blocking action may produce an excessive reduction of resting sympathetic nervous ac which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthos hypotension.
Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studi both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of signifi drug-induced toxicity. There were no drug-related tumorigenic effects at any of the do levels. Reproductive studies in animals did not show any impairment of fertility that attributable to the drug.
Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotox animal studies at doses about 10 times greater than the maximum recommended human c
There are no adequate and well-controlled studies in pregnant women. INDERAL sh be used during pregnancy only if the potential benefit justifies the potential risk to the f
Nursing Mothers. INDERAL is excreted in human milk. Caution should be exercised w INDERAL is administered to a nursing woman.
Pediatric Use. Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and rarely required the withdrawal of therapy.
Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; h tension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually c Raynaud type.
Central Nervous System: lightheadedness; mental depression manifested by insor lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; v disturbances; hallucinations; an acute reversible syndrome characterized by disorientatic time and place, short-term memory loss, emotional lability, slightly clouded sensorium, decreased performance on neuropsychometrics.
Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarr constipation; mesenteric arterial thrombosis, ischemic colitis.
Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with ac and sore throat, laryngospasm and respiratory distress.
Respiratory: bronchospasm.
Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytop purpura.
Auto-Immune: In extremely rare instances, systemic lupus erythematosus has b reported.
Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male ir tence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reac involving the skin, serous membranes and conjunctivae reported for a beta blocker (prac have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride sustained-release capsule for administration once daily. If patients are switched from INDE tablets to INDERAL LA capsules, care should be taken to assure that the desired therap effect is maintained. INDERAL LA should not be considered a simple mg for mg substitut INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration be necessary especially to maintain effectiveness at the end of the 24-hour dosing inte
HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 INDERAL LA once daily, whether used alone or added to a diuretic. The dosage ma increased to 120 mg once daily or higher until adequate blood-pressure control is achie The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage o mg may be required. The time needed for full hypertensive response to a given dosa variable and may range from a few days to several weeks.
ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERA once daily, dosage should be gradually increased at three to seven day intervals until opti response is obtained. Although individual patients may respond at any dosage level average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value safety of dosage exceeding 320 mg per day have not been established.
If treatment is to be discontinued, reduce dosage gradually over a period of a few w (see WARNINGS).
MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERA once daily. The usual effective dose range is 160-240 mg once daily. The dosage ma increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response obtained within four to six weeks after reaching the maximum dose, INDERAL LA the should be discontinued. It may be advisable to withdraw the drug gradually over a peri several weeks.
HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.
PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group ar limited to permit adequate directions for use.
*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laborat
8950

Ayerst AYERST LABORATORIES
New York, N.Y. 10017

Courses and Contracts

Clinicolegal Correspondence Course; Lawyers, Beware; Climate Improving for Malpractice Tort Reform

Over the last several years, professional liability lawsuits have become a part of the practice of edicine. While in theory, the central issue is the ality of medical care rendered, often factors which in the environment surrounding the question of atment decide whether the plaintiff or the defennt prevails. Such things as the manner in which atment is documented in the record or the way in ich a defendant handles an attorney's questions are important as the facts of the case. Additionally, in rtain cases a prior knowledge of what the law reires may have enabled the physician to avoid becomg involved in the suit in the first place.

Recognizing a need to provide information on the w as it applies to the practice of medicine, the leaderip of the Medical Inter-Insurance Exchange of New rsey (MIIENJ) commissioned Dr. James E. George, a ysician and an attorney, to develop a correspondnce course which would fill this need. This work was mpleted in late 1983, and since the course's troduction in January 1984, 2,500 physians have enrolled.

The course was written to inform the physician, ther than try to make him into a student of the legal nguage. It is divided into 24 chapters, each covering single major subject. It begins by reviewing basic gal principles, and progresses to such subjects as thdrawal of life-support systems, emergency psyiatric commitment, and countersuits. After prenting information on each subject, actual case citaons are presented to demonstrate how the law under discussion was applied. Each chapter ends with several test questions. After answering all of the questions, the answer sheet is returned to MIIENJ. The sheet is graded and returned to the physician with a pamphlet which gives an explanation of the answer to each question.

Upon successful completion of the course and the test, the physician is eligible for an award of 20 hours of Category I CME Credit (or Category 2-B in the CME program of the American Osteopathic Association, if appropriate). Also earned is a two-point reduction in any point total incurred under the High-Risk Evaluation Program. The course is free to any MIIENJ insured, and is available to physicians insured by any other carrier at a fee of $75. Anyone interested can obtain a copy by sending name, address, and specialty to the Risk Prevention Department, Medical Inter-Insurance Exchange of New Jersey, P.O. Box 6470, Lawrenceville, NJ 08648.

LAWYERS, BEWARE!

New Jersey is cracking down on lawyers who bilk clients or engage in unethical conduct. Last year 1,967 complaints were filed against lawyers, while in 1982 exactly 2,038 complaints were lodged, the State Division of Consumer Affairs said.

Last year there were 319 ethics complaints lodged against New Jersey doctors, 233 against 14,500 dentists, and 95 against 90,717 nurses, division Director, James Barry said. (*Trentonian*, March 20, 1984)

CLIMATE IMPROVING FOR MALPRACTICE TORT REFORM

The public climate for tort reform may be improving. A yearly public opinion survey, conducted by an independent firm for the American Medical Association last year, shows growing support for limits on the amount of money that could be awarded in a malpractice suit. Nearly two-thirds (62 percent) said they favored such a cap.

In a 1982 survey, public respondents flatly rejected giving up the right to sue for malpractice, but increasing concern about rising health care costs apparently has made the ceiling on awards more acceptable.

The public also may be developing an increasing perception that some malpractice suits are without merit. When asked if people who sue physicians usually are justified in bringing suit, the number who said yes dropped from 47 percent in 1982 to 41 percent in 1983. The number who said people who sued were "just looking for an easy way to make money" rose from 43 percent in 1982 to 47 percent in 1983.

Slightly less than half of the respondents said juries awarded too much money to successful plaintiffs in malpractice suits while about one-third said the amounts awarded were about right. (*Loss Minimizer*, February 1984)

---

*This item from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse who are, respectively, Director of the Department and Director of Special Projects.

FIFTH ANNUAL MEDICOLEGAL SEMINAR

Wednesday, September 12, 1984
8:30 a.m.- 4:00 p.m.

Medical Society of New Jersey Executive Offices
Two Princess Road
Lawrenceville, NJ 08648
presented by

Medical Society of New Jersey
Department of Professional
Liability Control

Medical Inter-Insurance
Exchange of New Jersey
Department of Risk Management

Morning Session

8:30 Registration and Coffee

9:00 Greetings
Frank Y. Watson, M.D., President, MSNJ and James S. Todd, M.D., Chairman of the Board, MIIENJ

9:20 **Opening Remarks**
James E. George, M.D., J.D., Director, Department of Professional Liability Control

9:45 **"The Snitch Bills; Their Impact on Medical Malpractice"**
Vincent A. Maressa, Executive Director, MSNJ

10:15 **"Reporting of Medical Malpractice To State Board of Medical Examiners"**
Joseph A. Riggs, M.D., Member of State Board of Medical Examiners

10:45 **"The New Case Management and Procedures of Malpractice Litigation"**
Honorable Peter Ciolino, Assignment Judge Superior Court, Passaic County

11:15 **Questions and Answers**

Afternoon Session

12:00 Lunch

12:45 **"Medical Malpractice; The View from the Chair"**
James S. Todd, M.D. Chairman, Board of MIIENJ

1:00 **"The Professional Liability World Today; The State of the Industry"**
Peter Sweetland, President, MIIENJ

1:45 **"The Claim Climate in New Jersey; A History and a Look at the Future"**
Joseph DeRoma, Vice-President, Claims, MIIENJ

2:30 **"An Ounce of Prevention; Causes of Suits and Programs Developed To Avoid Them"**
Adam P. Wilczek, Director, Department of Risk Management, MIIENJ

3:15 **Questions and Answers**

APPROVED FOR 5½ CME CATEGORY I CREDITS

REGISTRATION
PLEASE RESPOND NO LATER THAN AUGUST 31, 1984
NO REFUNDS AFTER SEPTEMBER 10, 1984

MSNJ MEMBER OR MIIENJ INSURED	$10.00
NON MSNJ MEMBER OR NOT INSURED WITH MIIENJ	25.00

DETACH AND MAIL TO MSNJ, TWO PRINCESS ROAD, LAWRENCEVILLE, NJ 08648

Enclosed is my check for_____payable to MSNJ

NAME (PLEASE PRINT)_____

ADDRESS_____

PHONE #_____

A CONFIRMATION WILL BE SENT TO YOU ALONG WITH DIRECTIONS TO MSNJ.

TAX SHELTERS

Just one of the personal financial services available to you from the ***physician's bank.***

- tax planning
- lines of credit
- equipment financing
- retirement planning

- money management
- cash flow • investments
- estate planning

Call or Write
Joseph J. Verbaro, Jr.
Senior Vice President
(201) 228-9770

FINTRUST
FINANCIAL AND TRUST SERVICES
DIVISION OF SECURITY NATIONAL BANK & TRUST COMPANY OF NEW JERSEY
101 Eisenhower Parkway
Roseland, New Jersey 07068 Member F.D.I.C.

SUPPOSITORY THERAPY

DESIGNED FOR YOUR SPECIALTY.

VAGINAL	RECTAL	URETHRAL
Progesterone	Hydrocortisone	Nitrofurantoin (Plain & with HC)
Boric Acid	Lidocaine	Hydrocortisone
Ampicillin/ Nystatin	Analgesic	Tetracycline
	Emollient	Lidocaine
	Progesterone (including rectal soln's)	SMZ-TMP

All preparations are available in your choice of potency and are prepared in heat stable bases suitable for shipping via United Parcel Service (UPS) with next day delivery within a 300 mile radius.

Contact us for any special requirements that exist in your practice.

BELVIDERE PHARMACY & SURGICAL
1101 South Avenue
Plainfield, New Jersey 07062 (201) 756-6695

PRIMARY CARE PRACTITIONERS. LET US HELP YOU SHORTEN THE ROAD TO PROFESSIONAL SUCCESS!

As the HMO of Private Physician's Offices, we are America's fastest growing health care system. Our network of participating primary health care physicians is expanding so rapidly that in some areas, we have more patients than doctors. We need your help.

Interested in establishing a practice in Florida, New Jersey or Southeastern Pennsylvania? We can:

- Introduce you to a number of our primary care physicians who want to expand their private practices and are looking for associates.
- Help you set up your own practice by arranging low interest loans and enrolling our health plan patients in your office.

So if you are a young doctor, Board Certified and residency trained, send us a resume and an indication of your professional objectives. Let us help you fulfill your career and financial goals.

Write: Medical Director
United States Health Care Systems
980 Jolly Road, P.O. Box 1109
Blue Bell, PA 19422

Or Call: 1-215-283-6888

HMO FLORIDA
HMO PENNSYLVANIA
HMO NEW JERSEY

United States Health Care Systems Companies

Motrin®
ibuprofen, Upjohn
600 mg Tablets



More convenient for your patients.

Upjohn

©1984 The Upjohn Company

The Upjohn Company • Kalamazoo, Michigan 49001 USA

J-4044 Janu

The Academy of Medicine of New Jersey Awards

The Academy of Medicine of New Jersey held their Annual Awards Dinner on May 23, 1984, and honored AMNJ President Rigolosi and Dr. Alessi, the Edward J. Ill Award recipient.

The Academy of Medicine attendees of the Annual Awards Dinner (May 23, 1984) received an riginal limited edition print by Richard Kemble of Vashington Crossing, Pennsylvania. The print, reproduced on our cover, is an image which is a semi-abtract impression entitled, "Mercer Oak," the Oak tree n Princeton Battlefield. Kemble's travels and studies n Japan inspired his interpretation by way of apanese calligraphy.

At the Awards Dinner, Robert S. Rigolosi, M.D., was naugurated as the new president of The Academy of Iedicine of New Jersey.

Medicine or boxing ... which would it be? That decision had to be made by Bob Rigolosi in his senior ear in college when he advanced to the finals of the lympic trials and had the opportunity to travel to Ielbourne, Australia, with the United States Olympic eam. For a tough kid of immigrant parents, born and aised in Garfield, boxing would appear to be the likely hoice, but, as we know, our new President chose medine.

Foregoing a boxing career, Dr. Rigolosi graduated rom Syracuse University and went on to the Univerity of Rome Medical School. After that, it was an inernship at Hackensack Hospital and a residency at ronx V.A. Hospital. Awarded a fellowship by the Naional Institutes of Health, Dr. Rigolosi then studied enal-metabolic diseases for two years at Georgetown niversity Hospital.

Following his fellowship, Dr. Rigolosi got together vith Holy Name Hospital, Teaneck, to start the Reional Hemodialysis Center. From an inauspicious beinning in the hospital basement in 1969, the Center nder Dr. Rigolosi grew to one of the largest hemodialysis facilities in New Jersey and to one of the largest community hospital units in the country.



Robert S. Rigolosi, M.D.

But his dedication to his profession extended far beyond his work at Holy Name Hospital. He got involved, very involved.

In 1969, Governor Cahill appointed Dr. Rigolosi to the Chronic Renal Disease Advisory Committee of the Department of Health. During the next eight years, he

was elected its chairman on three occasions.

In 1977, he was elected president of the Bergen County Medical Society.

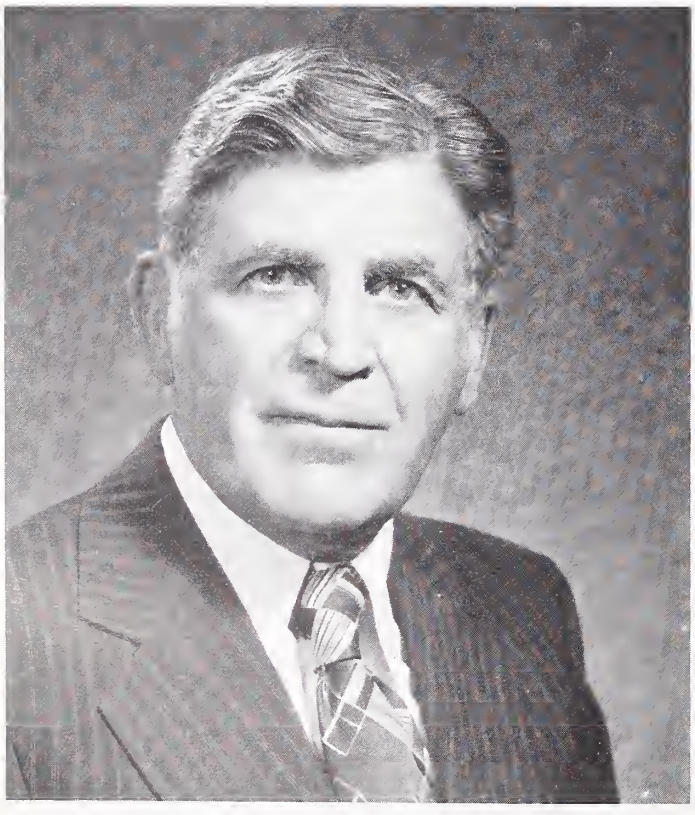
In 1979, Governor Byrne appointed our President as a trustee of the Statewide Health Coordinating Council (SHCC), a position he still holds.

In 1980, Dr. Rigolosi was elected chairman of the Bergen—Passaic Health Systems Agency (HSA), the first physician ever elected to the top post of any HSA in the state.

Dr. Rigolosi has been a member of The Academy of Medicine since 1970, having actively served on several committees, including medical education and membership. He has been a Trustee since 1977.

The contributions which Dr. Rigolosi has made to the medical community, and beyond, have been recognized by such charitable organizations as the National Council of Christians and Jews, which presented him with their Brotherhood Award in 1978 ... by the Bergen County Boys Town of Italy, which gave him the Citizen of the Year Award in 1981 ... by the National Kidney Foundation of New York/New Jersey, which honored Dr. Rigolosi with the National Medical Award in 1983.

Dr. Rigolosi lives in Paramus with "my raison d'etre,"



Alfred A. Alessi, M.D.

Marguerite, and their four children—Robert, Rebecc Luke, and Laura.

Alfred A. Alessi, M.D., a vascular surgeon from O adell, is the 1984 recipient of The Academy of Medicin of New Jersey's Edward J. Ill Award.

Born in New York City, he grew up in Rutherfor where he was graduated from high school. He receive his premedical education at Colgate University and hi medical degree from the New York University Colleg of Medicine. In addition, he was granted an M.S. fro Fairleigh Dickinson University.

Dr. Alessi served internships and surgical res dencies at the City Hospital, New York, between 193 and 1942. During the period 1942 to 1945, he was i the US Army at the 14th Evacuation Hospital in Indi where he attained the rank of major and was decorate with the Bronze Star for Meritorious Service.

Life has been a mixture of surgical practice an service to medicine for Dr. Alessi. In addition to bein the past director of surgery and past chief of vascula surgery at the Hackensack Medical Center, he ha served as chairman of numerous committees of tha hospital and as a member of its Committee of Director and its Board of Governors. His service to the Berge County Medical Society and the Medical Society of Ne Jersey has been tireless, having served as their pres dents in 1974 to 1975 and 1979 to 1980, respectivel

Dr. Alessi is recognized as the first vascular surgeo to be established in New Jersey (1946) and has helpe train over 1,500 surgical residents at the Hackensac Medical Center. He has been a president of the Amer can College of Surgeons, New Jersey Chapter, a mem ber of the New Jersey Regional Medical Program, an numerous national vascular societies. He is Diplomate of the American Board of Surgery and Fellow of the American College of Surgeons as well a the International College of Surgeons. He serves a director of medical education for The Academy of Med cine as well as being a member of its Board of Trustee

He has authored a number of scientific papers o various surgical topics and currently serves as Clinic Professor of Surgery at the UMDNJ-New Jersey Medic School. He also serves as Adjunct Professor of Huma Physiology at the Fairleigh Dickinson University.

In the last year and one-half he has traveled ove 65,000 miles on behalf of the American Medical As sociation addressing the impacts, concerns, and im plications of the DRG program.

Dr. Alessi is married to the former Isabel Molinar and they are the parents of four children—Joan, Alfre Louise and Thomas.

MSNJ: 218th Annual Meeting

he MSNJ Annual Meeting, May 3 to 6, 984, had its exciting and significant ioments.

America's first Medical Society had its 218th Annual Meeting at Resorts International in At-tic City. A new president was elected and the office chairman of the Board of Trustees was eliminated. nceforth the president will act as the chief executive cer of the Society.

rank Y. Watson was inaugurated as the 192nd sident of the Medical Society of New Jersey. In his roduction to the House of Delegates, Dr. L. Arne lbred made the following remarks:

It is an honor and a pleasure for me to introduce you my long-time friend, Frank Watson, as the 2nd President of the Medical Society of New Jersey. When we pick a president for our organization, we k for leadership qualities. In my opinion, the four st important qualities are experience, intelligence, nmitment, and political awareness:

Frank Watson has experience as a leader. He has n director of the laboratories at The Mountainside spital for the past 11 years. He has been president The Mountainside Hospital medical staff for 2 years l has been president of Essex County Medical So-ty. He has been on the Board of Trustees of the dical Society of New Jersey and an officer of the dical Society of New Jersey for the past several years. After many years of association, I can testify that nk Watson knows all the answers. After all, he is chief pathologist at my hospital and I am a sur-n; he is the one who always tells me the answer. Frank Watson also had the "smarts" to marry Dr. Carolyn Watson. We are indeed fortunate to have an outstanding husband/wife team with an interest in organized medicine; both are alternate delegates to the AMA House of Delegates.

"Anyone who knows Frank Watson knows his serious approach to any job or any problem. He doesn't shirk any responsibility. His commitment to the Medical Society of New Jersey can be exemplified by his many trips from his home in Glen Ridge to Trenton and Lawrenceville, in good weather and bad, over the past ten years to attend committee meetings, Board of Trustee meetings, and legislative hearings.

"In these troubled times for medicine, with more and more legislative and regulatory interference, we are fortunate to have Frank Watson as a president. He has had a special interest in legislative matters. He has been chairman of JEMPAC and represented us at legislative hearings.

Frank Watson is the most appropriate person to be President of the Medical Society of New Jersey at this time."

The Board of Trustees issued the following report concerning specialty society representation in the Medical Society of New Jersey's House of Delegates:

Pursuant to the Bylaws, we considered the applications of 26 specialty societies for seating in this House. Thirteen of the societies met the standards established in our Bylaws. We, therefore recommend that the following specialty societies be granted Delegate status:*

New Jersey Dermatological Society
New Jersey Gastroenterological Society
New Jersey Society of Internal Medicine
Neurological Association of New Jersey
New Jersey Neurosurgical Society
Oncology Society of New Jersey
New Jersey Academy of Ophthalmology and Otolaryngology
New Jersey Orthopaedic Society
New Jersey Society of Plastic and Reconstructive Surgeons
Radiological Society of New Jersey
New Jersey Chapter, American College of Surgeons
New Jersey Society of Thoracic Surgeons
Urologic Society of New Jersey

The following specialty societies met Bylaw criteria with one exception. They did not establish that 80 percent of their membership are members of the Medical Society of New Jersey. Consequently, they are not recommended for approval. They have been advised to reapply whenever the ratio of their Medical Society of New Jersey membership improves:

New Jersey Allergy Society
New Jersey State Society of Anesthesiologists
American College of Chest Physicians, New Jersey Chapter
New Jersey Society of Colon and Rectal Surgeons
American College of Emergency Physicians, New Jersey Chapter
New Jersey Academy of Family Physicians
Nephrology Society of New Jersey
Obstetrical and Gynecological Society of New Jersey
New Jersey Society of Pathologists

American Academy of Pediatrics, New Jersey Chapter
New Jersey Society of Physical Medicine and Rehabilitation
American College of Physicians of New Jersey
New Jersey Psychiatric Association

*Under the Bylaws, the Medical Society of New Jersey Student Association is considered a specialty society, and its members are recognized as members of the Medical Society of New Jersey.

It is sad that such important groups as the anesthesiologists, the internists in the American College of Physicians, the family practitioners, the obstetricians, and the others are not "in the fold." The 80 percent rule may seem stringent, but I can think of no acceptable excuse for failure to belong to the blanket medical organizations—the American Medical Association and the Medical Society of New Jersey—which are the physicians' only hope to preserve any fraction of independence. As important as the specialty societies are, they cannot have the political clout nationally or in New Jersey that makes a difference.

The Medical Society of New Jersey has established a Hospital Medical Staff Section for the first time, in accordance with an AMA House of Delegates resolution (1983). The anticipated benefits of the new section both to MSNJ and to each hospital medical staff are as follows:

1. Provide a system to solve problems and to avoid polarization of medical staffs and other groups of physicians.
2. Provide a vehicle to identify the implications of future trends on the role of physicians individually and as members of medical staffs.
3. Acquaint medical staff leadership with policy structure in organized medicine.
4. Provide appropriate support to local and state medical staff representatives.
5. Develop and maintain information on issues of common concern to medical staffs and distribute data on successful approaches.
6. Provide an easy contact point for medical staff leaders with AMA and MSNJ resources.

The Committee on Annual Meeting sent shock waves through Reference Committee "B" and the House of Delegates when it announced that no suitable site could be found in New Jersey for the 219th Annual Meeting, May 2 to 5, 1985. The Board and the Committee worked diligently, but Resorts International was interested more in gamblers than in New Jersey physicians. Since no suitable alternative location was available, the decision to use the Americana Host Farm Resort and Conference Center in Lancaster, Pennsylvania, was made.

"Mandatory assignment" were buzz words this year. The House adopted two key resolutions:

- That the Medical Society of New Jersey request the American Medical Association to oppose vigorously any attempt by Congress to direct in any fashion mandatory assignment under Medicare.
- That the Medical Society of New Jersey resea the constitutionality of the concept of mandat assignment being proposed by Congress or a other proposal to force physicians to acc prestipulated fees.

Dr. Donald J. Holtzman, president of Union Cou Medical Society read a statement on the subject to t House; a portion states:

"Thursday, April 12, 1984, was a crucial day American medicine. On that day, the American Medi Association fought back an attempt to impose involu tary servitude by the government upon every pract ing physician in the United States.

"If mandatory assignment had passed, you wou have been required to sign an agreement with yo hospital to accept Medicare assignment for all inp tient care or lose all staff privileges. In effect, you wou not have been able to work at your profession.

"If it had not been for organized medicine, th would be your plight today. If it had not been for t voluntary freeze in fees, a mandatory freeze would n be in effect.

"This incredible effort to prevent your financ enslavement must not go unnoticed by you. Any doct who does not belong to the AMA should not let th day pass without writing out a check for his du What a small price to pay for their service to you."

The House also adopted two relevant resolutio dealing with compensation for physicians' services

- That the Medical Society of New Jersey develop contingency plan to enable the Society, or an o ganization it sponsors, to act as a collectiv bargaining agent for its members, and that th AMA be asked to develop similar plans.
- That the House of Delegates of MSNJ demand th Blue Shield and all major medical insurance ca riers permit access both by participating and no participating physicians to any major medical i surance coverage sold as part of a benefits pac age and that legal action be taken as deemed a propriate by the Board of Trustees if this dema is not respected.

The House adopted a resolution (and a propose special assessment for funding) for an important pul lic education program:

- That the Medical Society of New Jersey condu a "patient education" program, designed to in form the general public regarding the unde publicized factors involved in health care cost and the threat posed to the quality and avai ability of said care.

The 218th Annual Meeting had its exciting and sig nificant moments. Those physicians who fail to com prehend the importance of membership in the Amer can Medical Association and the Medical Society o New Jersey are making a mistake.

With a touch of irony, the Medical Society of Ne Jersey's democratic assemblage will meet for the 219t time since 1766 in, of all places, Pennsylvania. We hop to see you there. A.I

Salaried Physicians (Pathologists) and Due Process Hearings

VINCENT A. MARESSA, J.D.

The U.S. Court of Appeals held that a hospital may terminate an employment contract with its director of pathology without due process procedures.

A Federal District Court decision in Minnesota regarding salaried physicians has been affirmed by ıe United States Court of Appeals for the Eighth ircuit. This case, Engelstad *v* Virginia Municipal Hosital, No. 83-1411 (8 Cir., September 29, 1983), is sigificant to physicians and hospital governing boards.

The Court held that a hospital may terminate an mployment contract with its director of pathology ithout affording "due process" procedures, including hearing before the hospital's executive committee, hich is called for by the hospital's bylaws.

The pathologist was functioning under a long-standng oral agreement. He was terminated for failure to roperly supervise personnel and for ineffective mangement. He also was in frequent conflict with the dministration and the medical staff. Although terıinating his employee status, the hospital did not isturb his staff privileges.

The doctor filed the lawsuit as a federal civil rights ction. The Court rejected his argument on that issue nd said the case must be decided as a matter of ontract law. Employment contracts are terminable at ill unless there is a specific contractual understanding to the contrary.

The pathologist then attempted to argue that the termination of his employment resulted in a reduction of staff privileges without a due process hearing under the hospital's bylaws. The Court did not accept this argument. It viewed staff privileges as guaranteed authority but not the "wherewithal" to practice his profession. It stated the hospital had the right to terminate the "wherewithal" at its options without due process hearings which are afforded to doctors whose privileges are challenged because of alleged incompetence or unethical behavior.

While there are no reported New Jersey cases dealing with this particular situation, it is reasonable to assume that our courts would reach the same conclusion.

Salaried physicians and hospitals would be well advised to utilize the protection afforded both parties by properly executed written contracts and to pay particular attention to a clearly written termination clause.

*The material for this column is coedited by Arthur Krosnick, M.D., Editor, *The Journal*, MSNJ; Vincent A. Maressa, J.D., Executive Director, MSNJ; and James E. George, M.D., J.D., Director of Professional Liability, MSNJ.

DOCUMENTED IN THE SLEEP LABORATORY[1-5]...



ONLY DALMANE (flurazepam HCl/Roche) PROVIDES ALL THESE BENEFITS FOR RESTFUL SLEEP

- Rapid sleep onset[1-
- More total time asleep[1-
- Undiminished efficacy for at least 28 consecutive nights[2-
- Patients usually awake rested and refreshed[7-
- Avoids causing early awakenings or rebound insomnia after discontinuation[2,5,10-1

Copyright © 1984 by Roche Products Inc. All rights reserved.


PROVEN IN
THE PATIENT'S HOME
BECAUSE THERE IS NO SUBSTITUTE
FOR EXPERIENCE
DALMANE®
flurazepam HCl/Roche
STANDS APART
15-MG/30-MG CAPSULES
Caution patients about driving, operating hazardous machinery or drinking alcohol during therapy. Limit dose to 15 mg in elderly or debilitated patients. Contraindicated during pregnancy.
ROCHE
See next page for references and summary of product information

DALMANE® ℞
flurazepam HCl/Roche

References: **1.** Kales J *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol 3*:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **9.** Amrein R *et al: Drugs Exp Clin Res 9*(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol 3*:303-326, May 1981. **11.** Greenblatt DJ *et al: Sleep* 5(Suppl 1):S18-S27, 1982. **12.** Kales A *et al: Pharmacology 26*:121-137, 1983.

DALMANE® ℞
flurazepam HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g , operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE® Roche Products Inc.
Manati, Puerto Rico 00701

DOCTORS:

Are your billing, filing and business systems in your office running as smoothly and efficiently as your medical practice?

If not, Mary Ann Hamburger, Associates is your answer. Sixteen years ago Mary Ann Hamburger of Maplewood, New Jersey took a job for a doctor managing this office. Today, as a medical management consultant, Mary Ann knows where the problem areas are and she can make sure that everything runs smoothly for the physician and his or her staff. Part of her job is to make certain that the current billing system is running efficiently, to update the filing system, work with third party billing, help clear up any booking problems as far as appointments are concerned and work with any other problems relating to the business side of the medical practice.

Mary Ann's skills will benefit any doctor in an existing practice and all new doctors who are setting up their practices in the near future. Her services can also include the hiring aspect of the doctor's offices if desired.

FOR FURTHER INFORMATION ON MEDICAL MANAGEMENT, CONTACT MARY ANN HAMBURGER, ASSOCIATES AT 201-763-7394.

NEW YORK FERTILITY RESEARCH FOUNDATION, INC.

For the Investigation of
Problems of Human Infertility

The Foundation provides a complete diagnostic and consultation service for infertile couples. Investigations are conducted by well-known specialists in conjunction with consultants in the various fields of medicine related to infertility.

The Foundation is supported by an in-house modern laboratory equipped to do most tests required for diagnosis and treatment. Literature on request.

1430 Second Avenue, Suite 103
New York, N.Y. 10021
Phone: (212) 744-5500

)UT-OF-HOSPITAL BIRTHS: A SURVEY OF PARENTS

MARGARET GREGORY, M.D., ROBERTA B. McDONOUGH, R.N., LINDA MACIOROWSKI, R.N., EVA MILLER, M.S., TRENTON*

Questionnaires were mailed to 900 families, of whom 300 had out-of-hospital births and 600 had inhospital births; 695 questionnaires were deliverable. Of the families reached, 469 (67.4 percent) responded. Contact and response rates did not justify sweeping conclusions but there were indications of differences in services given to separate groups.

Out-of-hospital births have increased in New Jersey over the last five years from 250 in 1976 546 in 1980. The percentage of births that occurred ıt-of-hospital increased from 0.27 percent in 1976 to 58 percent in 1980.

Little was known about the health needs of these others and children. For example, there was no way know if the babies received vitamin K or ophthalmia ophylaxis, if blood specimens were taken for PKU ıd for hypothyroidism screening, or if the mother quired treatment for complications of labor and de- ery, or received timely family planning services. The ıbsequent course of infant and child was unknown: ere was a suspicion that these babies might remain ıt of the health care system, not receiving immuniza- ons or other elements of good child health super- sion.

Outcome of out-of-hospital births and particularly of me births has been examined by Mehl et al.,[1] Sim- ons,[2] and Burnett et al.[3] However, there are no re- rts which answer these specific public health ques- ns about services given to mothers and children. For is reason, a questionnaire was sent to families ex- riencing births in and out of the hospital in 1979. ıe self-administered questionnaire included items out several services that mothers and/or children ould be expected to receive as part of good health ıpervision. It also asked for some other nonmedical information and for one subjective judgment.

The main intent of the questionnaire was to elicit information that would enable us to answer what we considered to be an important public health question: Did those mothers and babies who had out-of-hospital deliveries have special public health needs which mothers and babies having inhospital deliveries did not have, or had to a markedly lesser degree?

METHOD

A systematic random sample of 300 New Jersey mothers was chosen from among the 651 out-of-hospital births reported to New Jersey Vital Statistics in 1979. Two controls (mothers whose babies were born inhospital and mothers whose babies were born out-of-hospital) were selected for each case. Controls were selected from the pool of inhospital births after organizing the file by maternal residence, marital status, race, parity, maternal age (± three years), and date of birth. Residence was considered to be an important factor, both as a socioeconomic indicator and as an indicator of proximity to and availability of medical services. (For small municipalities it sometimes was impossible to find controls in the same municipality

*From the Maternal and Child Health Program, New Jersey State Department of Health. Correspondence may be addressed to Dr. Gregory, New Jersey State Department of Health, John Fitch Plaza, CN 360, Trenton, NJ 08625.

TABLE 1

Service to Babies

Service or Procedure Performed	Inhospital Births Planned	Inhospital Births Unplanned	Home Births Planned	Home Births Unplanned	Birthing Center Births Planned*	Other Births Unplanned*
Hemorrhagic disease of the newborn prophylaxis	20 (6.15%)	0	9 (16.98%)	1 (2.70%)	13 (38.24%)	0
Screening test (PKU and hypothyroidism)	271 (93.38)	2(66.67) (NA)	41 (77.36)	29 (78.38)	33 (97.06)	10 (90.91)
Ophthalmia neonatorum prophylaxis	226 (69.54)	2(66.67) (NA)	25 (47.17)	23 (62.16)	27 (79.41)	6 (54.55)
Immunizations started by three months	303 (93.23)	2(66.67) (NA)	36 (67.92)	30 (81.08)	28 (82.35)	10 (90.91)
Infant complications reported	68 (20.92)	1(33.33) (NA)	2 (3.77)	9 (24.32)	5 (14.71)	4 (36.36)
Total	325	3 (Plus NA)	53	37	34	11

NA=No answer; *=There were no unplanned birthing center births and no planned other births.

TABLE 2

Services to Mothers and Children

Services	Inhospital Births Planned	Inhospital Births Unplanned	Home Births Planned	Home Births Unplanned	Birthing Center Births Planned*	Other Births Unplanned*
Family planning advice	146 (44.92%)	2(66.67%) (NA)	25 (47.17%)	16 (43.24%)	28 (82.35%)	3 (27.27%)
Examination of baby by nurse or doctor within one week	264 (81.23)	1(33.33) (NA)	49 (92.45)	35 (94.59)	34 (100)	7 (63.64)
Visit by nurse or doctor within two weeks	112 (34.46)	2(66.67) (NA)	43 (81.13)	22 (59.46)	9 (26.47)	1 (9.09)
Examination of mother within six weeks	305 (93.85)	3(100) (NA)	45 (84.91)	33 (89.19)	32 (94.12)	9 (81.82)
Total	325	3	53	37	34	11

NA=No answer; *=There were no unplanned birthing center births and no planned other births.

so another municipality in the same county of similar population and per capita income was substituted.) While maternal education may be a relevant factor it was not used in selection of controls because it is not reliably reported on birth certificates.[4] The questionnaire is reproduced in the Figure. A Spanish version of the questionnaire and letter was prepared and used where indicated by information on the birth certificates.

The questionnaire was pretested for comprehensibility and ease of answering by four New Jersey State Department of Health employees. These employees recently had babies and were all nonhealth professionals. They all judged the questionnaire to be readily understandable and easy to answer.

The questionnaire was mailed along with a cover letter and a stamped, self-addressed return envelope. The cover letter included information on the purpose of the study, use of data, and a phone number to call if further questions or explanations could be provided. Parents were invited to phone about concerns. Items covered in the questionnaire are listed in Tables 1 to 3.

A followup mailing was sent two months after th first to those families who had not responded. Thi letter reminded the families of the first one, reassure them about the confidentiality of the survey, and in vited them to call the Maternal and Child Health Pr gram to speak to nurses about any concerns the might have.

While questionnaires were numerically coded so tha responses could be linked with information from th baby's birth certificate, confidentiality was maintaine by careful handling of numeric linkage lists, separ ation of these lists from the data, and security code in the computer library. Also, no individually iden tifiable data were maintained in written material re lated to the survey. A cut-off date of six weeks fro mailing was established.

Responses were compared for the two samples as a whole, using standard statistical techniques such a means, chi-square, and Fisher's exact test for dif ferences between the groups for categorical variables Matched analysis techniques could not be used be cause of the low response rates and small number o matched pairs in the final data set.

TABLE 3

Social and Economic Questions

Question	Inhospital Births Planned	Inhospital Births Unplanned	Home Births Planned	Home Births Unplanned	Birthing Center Births Planned*	Other Births Unplanned*
1. Why did you plan to have your baby born in the setting you chose?						
a. Cost was a factor.	21 (6.46%)	1 (33.33%)	10 (18.87%)	2 (5.41%)	15 (44.12%)	1 (9.09%)
b. Level of independence was factor.	12 (3.69)	1 (33.33)	41 (77.36)	1 (2.70)	27 (79.41)	0
c. Desired home-like setting.	6 (1.85)	2 (66.67)	47 (88.68)	0	31 (91.18)	0
d. Safety was factor.	273 (84.00)	1 (33.33)	30 (56.60)	28 (75.68)	16 (47.06)	8 (72.73)
e. Other.	53 (16.31)	1 (33.33)	14 (26.42)	2 (5.41)	10 (29.41)	3 (27.27)
2. Were you pleased with your birthing experience? Yes answers	279 (85.54)	1 (33.33)	52 (98.11)	33 (89.19)	34 (100.00)	7 (63.64)
3. Would you plan to give birth in the same place again? Yes answers	256 (78.77)	0	51 (96.23)	8 (21.62)	31 (91.18)	0
Total	325	3 (NA)	53	37	34	11

NA = No answer; * = There were no unplanned birthing center births and no planned other births.

SULTS AND DISCUSSION

)verall, 695 surveys were deliverable, (77.2 percent). the families reached, 469 (67.4 percent) responded. contacted 178 (59.4 percent) mothers having out-ıospital births and 517 (86.2 percent) mothers ving inhospital births. Of these 695 mothers con-ted, 137 (77 percent) of the 178 with out-of-hospital d 332 (64.2 percent) of the 517 with inhospital ths responded to the survey questions.

The overall response rate based on number of letters ıt out was 52.1 percent.

The number contacted and the response rates were appointing and the difference in the contact and ponse rates in the in- and out-of-hospital birth ups has diminished the confidence with which the ormation obtained can be used.

However, given these impediments, it still was con-ered worthwhile to study the responses from both ups.

Comparison of respondents and nonrespondents s made on the basis of sociodemographic variables ed on the birth certificates. Respondents were sig-icantly more likely to be married (87.1 percent for pondents compared to 69.7 for nonrespondents). spondents also were significantly likely to be older ean ages were 26.9 and 25.7 years, respectively), ite (86.5 percent as compared to 67.4 percent), and ter educated (12.9 years of formal education as com-ed to 12.0 years) than nonrespondents. No signifi-ıt differences were observed between respondents d nonrespondents with respect to county of resi-dence, parity, birth weight, or seasonality of birth.

Comparison of sociodemographic characteristics for the inhospital populations showed no statistically significant differences on county of residence, maternal age, maternal education, parity, birth weight, marital status, race, or seasonality of birth. Multiple births were significantly more likely to occur in hospitals.

Comparison of sociodemographic characteristics for the respondents between inhospital and out-of-hospital births showed no significant differences in marital status, race, county of residence, maternal age, parity, birth weight, or seasonality of birth. Mean education of out-of-hospital mothers tended to be slightly higher than that of inhospital mothers with a mean number of years of 13.1 compared to 12.8 years ($P \geq .08$).

Conclusions reached on the basis of these responses should be considered tentative and final conclusions will have to follow further studies.

Out-of-hospital births were organized into four categories, based on responses to the questions "Where was your baby born?" and "Where had you planned to have your baby?" These categories were planned home birth, unplanned home birth, birthing center birth, and other; "other" included locations such as automobiles and ambulances.

SERVICES TO BABIES

Questions on services given to babies were designed to determine whether the babies received those services considered part of good child health supervision appropriate to the age of the child when questioned.

Questions Regarding your Baby's Birth

Please answer the following questions. Feel free to write any comments on back.

1. Where was your baby born?
   - ☐ a. In a hospital
   - ☐ b. At home
   - ☐ c. In a birthing center
   - ☐ d. Other (please specify)

2. Did you choose to have your baby where it was born?
   ☐ Yes ☐ No ☐ Do Not Know

3. Where had you planned to have your baby born?
   - ☐ a. In a hospital
   - ☐ b. At home
   - ☐ c. In a birthing center
   - ☐ d. Other (please specify)

4. Why did you plan to have your baby born there? (Please specify, any or all)
   - ☐ a. Cost was a factor
   - ☐ b. Level of independence was a factor
   - ☐ c. Desired a home-like setting
   - ☐ d. Safety was a factor
   - ☐ e. Other (please specify)

5. Were you pleased with your birthing experience?
   ☐ Yes ☐ No ☐ Do Not Know

6. Would you plan to give birth again in the same place?
   ☐ Yes ☐ No ☐ Do Not Know

7. Did the baby have complications at or shortly after birth?
   - ☐ a. No, the baby did not have any complications.
   - ☐ b. Yes, the baby saw a doctor at his office because of complications.
   - ☐ c. Yes, the baby required a hospital stay because of complications.
   - ☐ d. Please specify problem.

8. Did you (the mother) have complications at or shortly after birth?
   - ☐ a. No, I (the mother) did not have any complications.
   - ☐ b. Yes, I (the mother) saw a doctor at his office because of complications.
   - ☐ c. Yes, I (the mother) required a hospital stay because of complications.
   - ☐ d. Please specify problem.

9. Did you receive family planning advice after the baby's birth?
   ☐ Yes ☐ No ☐ Do Not Know

10. Did your baby get an injection to prevent bleeding?
    ☐ Yes ☐ No ☐ Do Not Know

11. Did the baby have blood taken (from a heel stick) for a screening test?
    ☐ Yes ☐ No ☐ Do Not Know

12. Did your baby have drops placed in his/her eyes to prevent infection after birth?
    ☐ Yes ☐ No ☐ Do Not Know

13. Did your baby have its first shot (immunization) by three months of age?
    ☐ Yes ☐ No ☐ Do Not Know

14. Did a nurse or doctor examine the baby and/or you within one week after birth?
    ☐ Yes ☐ No ☐ Do Not Know

15. Did a nurse or doctor visit within two weeks?
    ☐ Yes ☐ No ☐ Do Not Know

16. Did you receive an examination within six weeks after the birth?
    ☐ Yes ☐ No ☐ Do Not Know

Figure—Questionnaire used by Maternal and Child Health program.

Answers to these questions are summarized in Table 1. These responses show that, according to the perception of the mother, and compared with hospital births:

Planned and unplanned home births equally were likely to have received hemorrhagic prophylaxis, though there was a nonsignificant tendency for planned home births to receive it. Birthing center births were significantly more likely to receive it; other births showed no difference.

There was a tendency for planned home births not to receive screening tests, although this tendency was not significant statistically. Unplanned home, birthing center, and other births showed no difference.

Planned home births were significantly less likely to have received ophthalmic prophylaxis; other births and unplanned home births showed no difference; birthing center births showed a nonsignificant tendency to receive it.

Planned home births were less likely to have begun immunizations by three months but the difference was not significant statistically; unplanned home, birthing center, and other births showed no difference.

Planned home births showed significantly less infant complications; all other births showed no difference.

SERVICES TO MOTHERS AND BABIES

Questions on services given to mothers and mother and child were designed to determine whether family planning counseling was given at an appropriate time and whether there was appropriate contact with health care providers.

The question on a visit by a doctor or nurse within two weeks of the birth caused some confusion in the respondents. It was intended primarily for mothers having out-of-hospital births, and many mothers having inhospital births were puzzled by it and wrote questioning comments after their negative responses.

Answers to questions on services to mothers and children are summarized in Table 2.

These responses show that, according to the perception of the mother, and compared with the hospital births:

Birthing center births were significantly more likely to receive family planning advice; all other types of births showed no difference.

Planned home and birthing center births were si

ficantly more likely to have the baby examined by a urse or doctor within one week; unplanned home rths showed a nonsignificant tendency to have aminations and other births showed no difference. Planned and unplanned home births were signifintly more likely to have a visit by a nurse or doctor ithin two weeks; birthing center and other births owed no difference.

Planned home births were less likely to show the other receiving an examination by six weeks; though ot significantly so; all other types of births showed o difference.

OCIAL AND ECONOMIC QUESTIONS

Some questions were largely social and economic; ese questions were intended to find the reasons why ecisions had been made about the birthing exerience and what future plans were made subsequent o it. Answers to social and economic questions are ummarized in Table 3.

These answers were all subjective judgments; differences were not tested for significance. However, it interesting that the most satisfied group was the irthing center mothers (34 or 100 percent were eased with their birthing experience and 31 or 91.18 ercent would plan to give birth in the same place gain). Also, there was very high satisfaction with anned home births.

ONCLUSION

Since review of the literature shows a paucity of iformation regarding out-of-hospital births, this udy has value as a basis for further exploration. Even ough the contact and response rates to this survey o not justify any firm conclusions, there are, however, indications that there are differences in the services given to individual groups. Planned home births, for example, seemed less likely than other groups to have received ophthalmic prophylaxis and also may have been less likely to have screening for inborn errors of metabolism and to have immunizations started by three months.

It must be remembered that the answers to the questions in this study reflect mothers' perceptions of the care provided during their birth experiences and do not necessarily show actual provision of services. One example of this discrepancy can be seen in the area of hemorrhagic disease prophylaxis which may have been administered on a regular basis to the hospital born infants without awareness on the part of the mother. The conclusions in this study then would be that more mothers delivering at birthing centers are aware of hemorrhagic disease prophylaxis for their newborns than mothers giving birth at hospitals.

Further studies which might have included review of hospital records as well as ascertaining perceptions of mothers and interviews of families, were not done due to funding limitations.

REFERENCES

1. Mehl LE, Peterson AH, Whitt M, Hawes WE: Outcomes of elective home births, a series of 1,146 cases. *J Repro Med* 19:51, 1977.
2. Simmons RS: Who chooses home birth and the impact of planning status on neonatal mortality and birthweight. Annual Meeting, American Public Health Association, 1980.
3. Burnett CA, Jones JA, Rooks J, Tyler CW, Miller CA: Home delivery and neonatal mortality in North Carolina. Annual Meeting, American Public Health Association, 1977.
4. Personal communication, Charles Karkut, Vital Statistics Registrar, New Jersey.



Angina Protection with Benefits for a Lifetime

ONCE-DAILY CONTROL WITH HEART-SAVING BENEFITS

By reducing heart rate and cardiac contractility, INDERAL LA helps protect the heart from the potentially serious and debilitating consequences of ischemia. A highly effective antianginal agent for around-the-clock control of symptoms, INDERAL LA also provides cardiovascular protection for a sense of security in the years ahead.

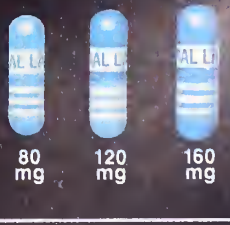
PROTECTION AND EXPERIENCE NO CALCIUM BLOCKER CAN MATCH

Unlike calcium blockers, INDERAL LA—either alone or with a nitrate—is recommended for early treatment of angina in the majority of patients. Equally important, INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use.

START WITH 80 MG ONCE DAILY

Dosage may be increased to 160 mg once daily, as needed, to achieve optimal control. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY **INDERAL LA** (PROPRANOLOL HCl) *LONG ACTING CAPSULES*

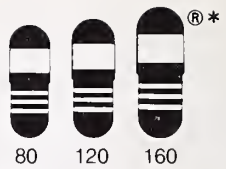


Ayerst®

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

JUST ONCE EACH DAY FOR SIMPLIFIED CORE THERAPY IN ANGINA

ONCE-DAILY INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking t prior to major surgery is controversial. It should be noted, however, that the impaired a the heart to respond to reflex adrenergic stimuli may augment the risks of general ane and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor o receptor agonists and its effects can be reversed by administration of such agents dobutamine or isoproterenol. However, such patients may be subject to protracted hypotension. Difficulty in starting and maintaining the heartbeat has also been reporte beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent th pearance of certain premonitory signs and symptoms (pulse rate and pressure chan acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may b difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyro Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of sym of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid functio

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have reported in which, after propranolol, the tachycardia was replaced by a severe brady requiring a demand pacemaker. In one case this resulted after an initial dose of propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with im hepatic or renal function. INDERAL is not indicated for the treatment of hyperte emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. P should be told that INDERAL may interfere with the glaucoma screening test. Withdraw lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart di elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as pine should be closely observed if INDERAL is administered. The added catechol blocking action may produce an excessive reduction of resting sympathetic nervous which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orth hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animal been conducted to evaluate toxic effects and carcinogenic potential. In 18-month stu both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of sign drug-induced toxicity. There were no drug-related tumorigenic effects at any of the d levels. Reproductive studies in animals did not show any impairment of fertility tha attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryot animal studies at doses about 10 times greater than the maximum recommended human There are no adequate and well-controlled studies in pregnant women. INDERAL s be used during pregnancy only if the potential benefit justifies the potential risk to the

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; tension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insc lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; disturbances; hallucinations; an acute reversible syndrome characterized by disorientat time and place, short-term memory loss, emotional lability, slightly clouded sensorium decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, dia constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with a and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocyto purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male tence, and Peyronie's disease have been reported rarely. Oculomucocutaneous rea involving the skin, serous membranes and conjunctivae reported for a beta blocker (pra have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochlori sustained-release capsule for administration once daily. If patients are switched from IND tablets to INDERAL LA capsules, care should be taken to assure that the desired therap effect is maintained. INDERAL LA should not be considered a simple mg for mg substitu INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitratio be necessary especially to maintain effectiveness at the end of the 24-hour dosing in

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 8 INDERAL LA once daily, whether used alone or added to a diuretic. The dosage m increased to 120 mg once daily or higher until adequate blood-pressure control is achi The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage mg may be required. The time needed for full hypertensive response to a given dos variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDER once daily, dosage should be gradually increased at three to seven day intervals until opt response is obtained. Although individual patients may respond at any dosage leve average optimum dosage appears to be 160 mg once daily. In angina pectoris, the valu safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few w (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDER once daily. The usual effective dose range is 160-240 mg once daily. The dosage m increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response obtained within four to six weeks after reaching the maximum dose, INDERAL LA th should be discontinued. It may be advisable to withdraw the drug gradually over a per several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.
PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group a limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Labora

883

Ayerst® AYERST LABORATORIES
New York, N.Y. 10017

Case Report: Alcoholic Cardiomyopathy

István A. Gáspár, M.D. Englewood*

A 12-year, two-pints whisky drinker developed cardiac failure. Fairly extensive degeneration and liquefaction of the sarcoplasm of the myocardial fibers, necrosis of myocardial fibers, and fibrosis were seen with light microscopy. Cardiomyopathy was a direct effect of excessive alcohol on the myocardium.

The direct action of alcohol on the myocardium was not seriously considered until about the id-20th century; yet it was recognized much earlier at alcohol causes myocardial damage. Today, al-holic damage of the myocardium is designated as coholic cardiomyopathy. Alcoholism is frequent and t the opportunity for histologic study of hearts from coholic cardiomyopathy is rare.

Light microscopic changes of the myocardium in coholic cardiomyopathy were thought to be unim-essive. However, reports of such studies are few. It as been found that only a number of alcoholics will velop alcoholic cardiac pathology, i.e. cardio-yopathy.

A case of fatal alcoholic cardiomyopathy occurred in 980 at Englewood Hospital. The observed light micro-opic pathological changes are worth reporting to nlarge our knowledge of the subject.

ASE REPORT

The patient was a 32-year-old, thin and dehydrated ack male, a known alcoholic for 12 years, who drank vo pints of whisky every day. At admission on Febru-y 17, 1980, he complained of a cold and cough with ague pain across his chest, but no fever or chills. epatomegaly and scleral icterus were obvious. The ngs were clear; respirations, 24/min; temperature, 7.4° F.(p.o.); and pulse, 146 and regular. Blood pressure was 100/70. There were no heart murmurs. The abdomen was distended. The reflexes were hypoactive and there was a very mild tremor. There was no evidence of gastrointestinal bleeding. Chest x-ray showed marked cardiac enlargement, congestive heart failure, fluid at the left base, and hepatomegaly.

He was treated with intravenous fluids containing sodium bicarbonate and thiamine.

Laboratory work on February 17, 1980, showed RBC, 3,500.000; Hgb, 11 gm/dl; WBC, 10,900; and 80% polys. Blood glucose was 125 mg/dl; uric acid, 18.0 mg/dl; total protein, 6.5 gm/dl; total bilirubin, 3.0 mg/dl; LDH, 1,300 units; SGOT, 1,000 units; and lipase, 1.0 unit. Urinalysis showed 3 + protein, and bile was positive.

On Feburary 18, 1980, the patient was in shock (blood pressure was 38/30). Cardiac arrest developed, but he was resuscitated. The serum pH was 7.01. On February 19, 1980, he became comatose and apneic. Laboratory reports showed serum pH, 6.9; and PO_2, 36 mm/Hg. A blood sample was negative for methylalcohol. In spite of vigorous treatment, he expired.

Postmortem examination was performed 20 hours after death. The peritoneal cavity contained 1,000 cc of ascitic fluid. There were 700 cc of left chest fluid, 800 cc of right chest fluid, and 90 cc of pericardial fluid. The lungs were markedly expanded, congested,

*From the Department of Pathology, Englewood Hospital. Correspondence may be addressed to Dr. Gáspár, 261 Glenwood Road, Englewood, NJ 07631.

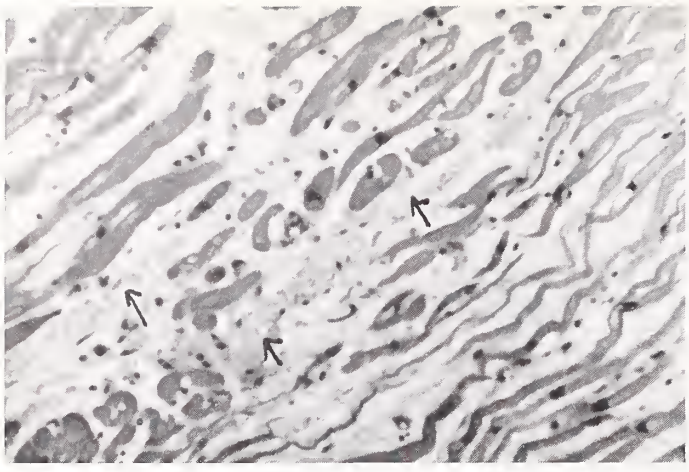


Figure 1—In the center of the field (arrows) there are necrotic myocardial fibers. Many of the other fibers show longitudinal sarcoplasmic degenerations, vacuoles and, particularly in the right half of the field, many thin, wavy, thread-like, and some fragmented fibers. (H&E, low magnification, 10 x N.A. .25)

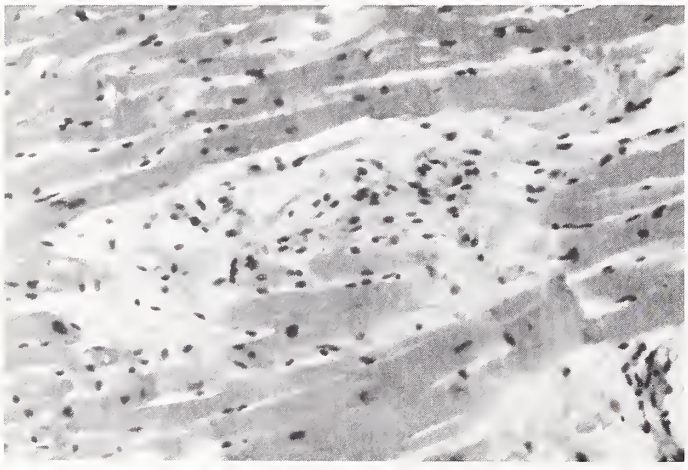


Figure 2—Small fibrous patch formed at site of myocardial necrosis. (H&E, high magnification, 45 x N.A. .66)



Figure 3—Small segmental liquefaction of myocardial fibers with disruption of the myofibrils (arrow). (H&E, high magnification, 45 x N.A. .66)

and heavy. The parenchyma was dark grayish-red, doughy, and very edematous. Culture was negative for pathogenic organisms. The heart weighed 420 gm. There was hypertrophy and dilatation of all chambers, particularly that of the right auricle and of both ventricles. Thrombus filled the right auricular appendage. The coronary arteries and the aorta showed only a few small fatty intimal spots. The myocardium was flabby, grayish-red, without grossly recognizable spots of fibrosis. The liver was slightly enlarged, weighing 1,835 gm. It was hard, reddish-yellow with faintly micro-



Figure 4—Degenerating segments of myocardial fibers w marked disruption of the myofibrils. A horse tail-like str ture is produced (arrow). (H&E, high magnification, 45 x N .66)

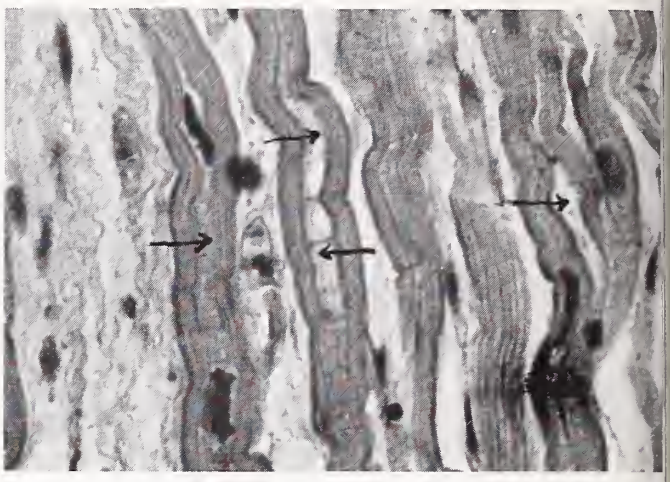


Figure 5—Elongated sarcoplasmic degenerations with spl ting of the myocardial fibers into thin strands (arrows). (H& high magnification, 45 x N.A. .66)

granular capsular surface. The gastrointestin mucosa was edematous.

LIGHT MICROSCOPIC STUDY

There were multiple scattered recent segment necroses of myocardial fibers (Figure 1). The necroti fibers broke up into larger masses of debris and als into small homogeneous granular particles. All thes disappeared, became absorbed, leaving a space i which lymphocytes and phagocytic cells were demor strable. There were scattered larger foci of stromal co lapse and early fibrous replacement, taking the plac of the almost entirely absorbed areas of myocardi necrosis (Figure 2). In many other areas there wer myocardial fibers with segmental liquefaction of th sarcoplasm and with disorganization of the myofibril (Figure 3). If a larger segment of the myocardial fibe was involved with the liquefaction of the sarcoplasm a horse tail-like structure was formed by the disrupte myocardial fibrils (Figure 4). Or, if the sarcoplasmi liquefaction involved multiple adjacent myocardi fibers, the cohesion of the myofibrils became so dis rupted that only a structure similar to a bunch of hair remained. When the myofibers were sectioned longi tudinally, numerous longitudinal clear spaces or split of varying size became apparent (Figure 5). On trans verse sections these sarcoplasmic liquefactions an degenerations appeared as vacuoles. This type of de

eneration of the sarcoplasm was fairly widespread nd it seemed that in multiple areas a sizeable per- entage of the myocardial fibers was affected in this ashion.

The liver showed very marked centrilobular passive ongestion. Fatty changes were extensive. Mallory bod- s were not demonstrable. Histology of the lungs cor- esponded with the gross pathological findings.

ISCUSSION

Since the 1960s, it has been appreciated that ex- essive alcohol intake may result in myocardial dam- ge independent of malnutrition or thiamine deficien- y or both. However, in 1884, Bollinger of Munich rec- gnized the relationship between heavy beer drinking nd cardiac hypertrophy and cardiac dilatation; he onsidered the latter as toxic manifestation of habitual eer alcoholism.[1] Alexander[2] and Gould[3] stated that he myocardial changes in alcoholic cardiomyopathy y light microscopy usually were focal, minimal, and ut of proportion to the severity of the clinical findings. acuolation of myocardial fibers was described by loor.[4] In my observation, the vacuoles occurred as uch when the myocardial fibers were sectioned trans- ersely and appeared anywhere in the myocardial ibers. They were the cross sections of the longitudinal arcoplasmic degenerations of the myocardial fibers.

Our patient's history fulfills the criteria of Brigden[5] nd puts his heart disease into the category of toxic ardiomyopathy. The important pathology was a fairly idespread segmental degeneration and liquefaction f the sarcoplasm of the myocardial fibers. The absence f necrotic myocardial fibers was stressed in several ertinent publications, but myocardial necrosis oc- curred in our patient. These degenerative changes are the result of the direct toxic action of alcohol on the myocardium. The irregularly thinned-out and often wavy myocardial fibers are not caused by atrophy but are caused by the longitudinal liquefaction of the sarcoplasm, which splits the myocardial fibers into multiple strips and, at times, into irregular-sized thin strands.

Damaging effects of excessive amounts of alcohol on the myocardium were demonstrated experimentally in mice and rats by Burch[6] and Maines.[7] The 12-year history of heavy alcohol abuse of our young patient is well within the 12- to 15-year time lapse when alcoholic cardiomyopathy develops. His death occurred as a result of congestive heart failure, i.e. pump failure as a consequence of alcoholic cardiomyopathy.

REFERENCES

1. Bollinger P: Ueber die häufigkeit und ursachen der idiopathischen herzhypertrophien in München. *Deutsche Medicinische Wochenschrift* 10:180-181, 1884.
2. Alexander CS: Idiopathic heart disease. 11. Electron microscopic examination of myocardial biopsy specimens in alcoholic heart disease. *Am J Med* 41:229-234, 1966.
3. Gould L: Cardiac effects of alcohol. *Am Heart J* 79:422-425, 1970.
4. Bloor CM: *Cardiac Pathology.* New York, NY, J.B. Lippincott Co. 1978.
5. Brigden W: Alcoholic cardiomyopathy. *Cardiovasc Clinics* 4(1):188-201, 1972.
6. Burch GE, Colcolough HL, Harb JM, Tsui CY: The effect of ingestion of ethyl alcohol, wine, and beer on the myocardium of mice. *Am J Cardiol* 27:522-528, 1971.
7. Maines, JE, Aldinger EE: Myocardial depression accompanying chronic consumption of alcohol. *Am Heart J* 73:55-63, 1967.

Thinking com

Think

As in Blue Cross of New Jersey. *The* single source for computerization.
☐ Because Medical Management Services from Blue Cross now offers a unique automated office system.
☐ Only Blue Cross offers this unique system, because only Blue Cross has the experience in the health care field (half a century's worth!), the data processing know-how and the claims processing expertise to make it all work efficiently and effectively.

The system itself.

You receive a stand-alone system using IBM or Texas Instruments computers that is physically located in your office. It is operated by your office personnel—they do not have to have any data processing experience—and the system is completely under their control at all times.

The software and system support.

This modular system provides a complete software package for your office which utilizes Blue Cross' expertise in health care financing, automated hospital admission/approval systems, automated claims submission, and leadership in paperless processing. Only Blue Cross can offer the benefits of this wealth of experience and offer single source capability for computerization.

Your people receive full and complete training and ongoing support in system operation. We accept full responsibility for hardware and software maintenance.

What the system does for the physician.

Whether you are an individual or group practice, this system will relieve paperwork...provide fast access to necessary patient information...and give you much more time to tend the clinical aspects of your practice and, above all, increase the efficie of the office and the income of th practice! All from a single source f computerization.

Some of what you get with the System:

- An easy-to-use system.
- Instant access to patient accoun information by account number.

Take a minute to check this list!

- ☐ Your volume is at least 80 patients per week.
- ☐ Your daily cash control and records keeping procedures need to be improved.
- ☐ Your receivables are greater than 17% of your total annual charges.
- ☐ You are forced to write off more than 5% of your net receivables as uncollectable.
- ☐ You are running behind in your insurance billings and collections.
- ☐ Your service bureau already charges you more than $4,200 per year.
- ☐ You experience a high turnover clerical employees or need to increase the productivity of your present staff.
- ☐ You find it difficult to get complete and current data on patien treatment patterns, facilities utili zation, and services on a regular weekly, monthly and annual basi
- ☐ Your quarterly and annual payrol reports are now done manually.
- ☐ You have difficulty getting useful management information about your practice when you need it.
- ☐ Your "most current" financial statement for the practice is already out of date.

If you have checked off any of the above, you are a candidate for Medical Management Services.

puterization?

blue.✓

Production of patients' statements on daily, weekly or monthly basis —whichever billing cycle is best for your practice.

Automatic production of standard insurance (AMA) claim forms.

A daily charge and collection summary which recaps all daily patient activity.

An aged accounts receivable trial balance which can be printed on demand.

Practice productivity reports broken down by procedures and payment classifications (insurance, self-pay, etc.)

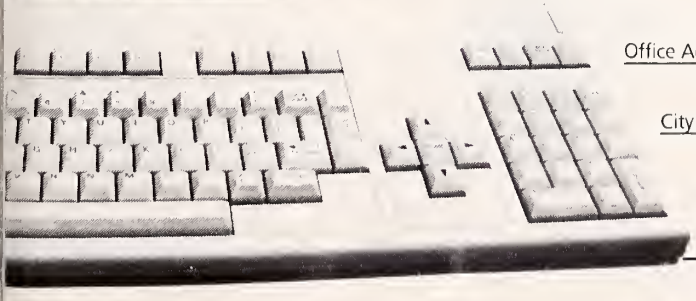
- Monthly management reports.
- Medicare payment distribution (20% of co-pay automatically calculated if assignment is accepted).
- Single-date entry for all financial transactions.
- A recall system which prints lists, statistics and "labels."
- Customized reports for special requirements.
- Automatic retention of claims information for rebilling purposes.
- Improvement in cash flow and office efficiency.

Free Office Analysis

Included in the services provided is a free office analysis where a Medical Management Services representative analyzes pertinent data on your current work flow, patient volume, initial set-up for new patients, billing, insurance filing and follow-up. This Office Analysis is a prerequisite for installation and is made at no charge.

Fill out the coupon, or call, for further details and to initiate your Office Analysis.





Medical Management Services

P.O. Box 8
Florham Park, NJ 07932
(201) 966-2710

Blue Cross of New Jersey ®

Medical Management Services
Blue Cross of New Jersey, P.O. Box 8, Florham Park, NJ 07932

☐ Please send me additional information.
☐ Please have a representative call to arrange an Office Analysis.

Dr. _____

Office Address _____

City _____

State/Zip _____ Office telephone _____

® Registered Marks Blue Cross and Blue Shield Association

Note: If you're new to medical practice in N.J. . .

You don't have to buy commercial malpractice insurance

JAMES S. TODD, M.D., *Chairman/Board of Directors, Medical Inter-Insurance Exchange of New Jersey*

AS you made your decision to establish yourself in New Jersey, you no doubt heard horror stories about our professional liability insurance problems. The legal risks we assume in this business have grown so far out of proportion that many commercial underwriters have been simply unable to cope, resulting in abrupt and often untimely suspension of coverage.

As a new practitioner in this State, either relocating or just beginning your professional career, you have an alternative to commercial insurance. The Medical Inter-Insurance Exchange provides an opportunity to build your new practice on the most secure footing possible with long-term peace of mind.

Founded in 1977 at the peak of the "premium crisis," the Exchange is a wholly doctor-owned cooperative organization through which we insure *ourselves* for our own sake. Membership has grown to two-thi of all practicing physicians and surgeons in t state. Because we're in it for security — *not for profit* — we can provide for ourselves tl absolute best available insurance product for the money. Every dollar we take in goes tow protection (no sales commissions) and every dollar left over is returned to us — in cash.

You owe it to yourself to know your options and the practicalities of each. We're here to help you sort them all out. Call and talk directly to our Vice President and Direc of Policyholder Services, Bill Reilly, **TOLL FREE (in N.J.) 800-257-6288** or (609) 896-2404 from other areas. We look forward to hearing from you.

A professional service message from the
Medical Inter-Insurance Exchange of N.J.
Two Princess Road, Lawrenceville NJ 08648
(609) 896-2404

Case Report: Tracheoesophageal Fistula and Arteriosclerotic Aortic Aneurysm

Raymond Schiffman, M.D., Camden*

An arteriosclerotic aneurysm of the thoracic aorta compressed the midesophagus. The pulsating aneurysm caused traumatic ulcers of the anterior and posterior walls of the esophagus. The ulcer in the anterior wall perforated into the lower trachea producing a tracheoesophageal fistula and bronchorrhea.

Most acquired fistulas between the esophagus and tracheobronchial tree result from carcinoma.[1] Review of acquired nonmalignant esophagorespiratory fistulas have emphasized infection and trauma as the chief causes.[1-3] In the case report described, a tracheoesophageal fistula formed as a result of repetitive trauma of the esophagus and trachea from a pulsating arteriosclerotic aortic aneurysm.

CASE REPORT

A 73-year-old white woman had a long history of dysphagia, which progressed to the point where she could swallow only liquids. She lost an unspecified amount of weight. Two days prior to admission to the hospital she became markedly dyspneic, developed a nonproductive cough, and refused to eat. Her symptoms did not improve after treatment with doxycycline and an antitussive agent and she was admitted to the hospital.

She was being treated for hypertension, pulmonary emphysema, a gastric ulcer, and a hiatal hernia. Gallbladder and cataracts from each eye had been removed previously. She had smoked 30 cigarettes a day for 50 years. Her son and mother had diabetes mellitus; her husband had been treated for tuberculosis.

On physical examination, her blood pressure was 132/78; her pulse, 142/minute; respirations, 32/minute; and rectal temperature, 97°F. Breath sounds were diminished in the right chest and expiratory wheezes were noted. The feet were cyanotic. No significant changes from previous x-rays were noted in a chest film. An electrocardiogram showed a supraventricular tachycardia with probable old inferior wall myocardial infarction, right bundle-branch block, and left anterior fascicular block.

Significant laboratory determinations included a hemoglobin of 11.3 gm/dl; a hematocrit of 34.7%; a fasting blood sugar of 321 mg/dl; a blood urea nitrogen of 54 mg/dl; and a creatinine of 3.3 mg/dl.

After being intubated she coughed up a large plug of mucus and then had copious serous secretions from the tracheobronchial tree. She was treated with aminophylline and verapamil but had to be placed on a respirator because of increasing respiratory distress and marked bronchorrhea. A culture of sputum grew normal flora. A blood culture was sterile. A urine culture grew a *Proteus* species in significant numbers and she was treated with Cefoxiten® and erythromycin.

On the second hospital day, a chest film was taken after a silicone feeding tube was passed and revealed the tube in the right pleural space (Figure 1). On the lateral view, a mass was noted behind the lower

*Dr. Schiffman is Acting Chief, Department of Pathology, Cooper Hospital/University Medical Center, Camden. Correspondence may be addressed to Dr. Schiffman, Cooper Hospital/University Medical Center, One Cooper Plaza, Camden, NJ 08103.

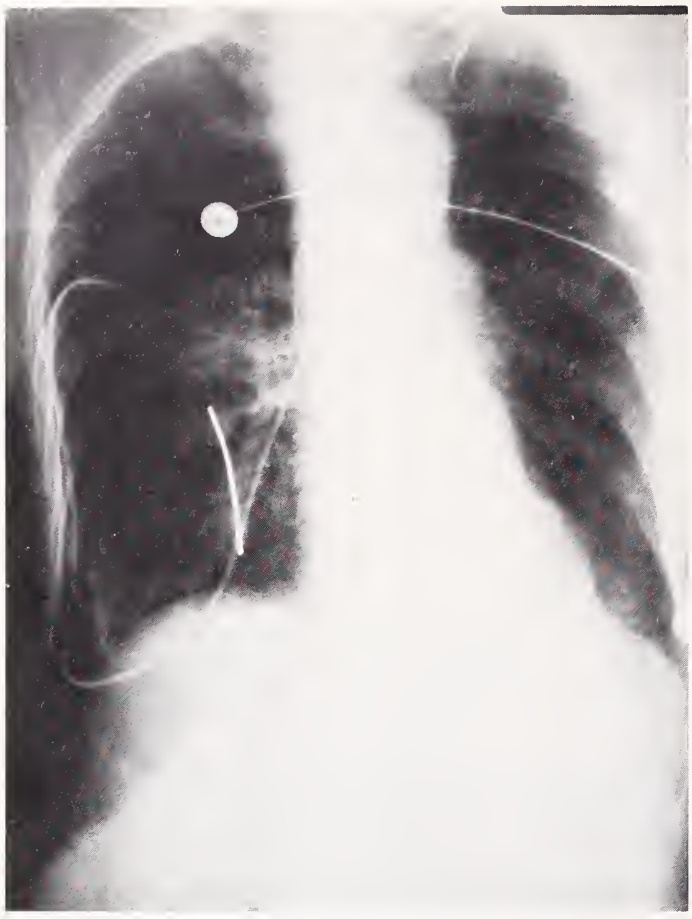


Figure 1—Chest film revealing silicone feeding tube in right pleural space.



Figure 2—Aneurysm of descending thoracic aorta—oper and viewed from behind.

trachea. Carbenicillin, tobramycin, and clindamycin were administered to combat mediastinitis.

The patient developed abdominal pain and her hemoglobin dropped to 6.7 gm/dl. Her dyspnea became more severe. *Candida tropicalis* was cultured from the sputum. Cells suspicious but not diagnostic for small cell carcinoma and cells suspicious of herpesvirus infection were noted in smears of sputum. A chest x-ray revealed bilateral basilar infiltrates with an alveolar pattern which was more pronounced on the right. The preterminal course was characterized by marked bronchorrhea and hypotension which required the administration of pressor agents. Massive pulmonary edema did not respond to furosemide therapy. By the ninth hospital day, she developed a markedly distended abdomen and a temperature of 101.2°F and died. Permission for autopsy was granted.

RESULTS

The immediate cause of death was a 1 cm sharply circumscribed ulcer in the posterior wall of the distal gastric antrum which perforated the gastric wall into the lesser sac and head of the pancreas. Pneumoperitoneum accounted for the abdominal distention. In the gastric body were a few additional small superficial ulcers.

Pulmonary emphysema and bronchiectasis were complicated by acute bronchitis with aspirated blood, acute pulmonary edema, and bilateral pleural effusions. There was no evidence of tuberculosis.

Arteriosclerotic cardiovascular disease was manifested by an old occlusion of the right coronary artery accompanied by old subendocardial infarcts of the diaphragmatic wall of the left ventricle and tip of t anterior papillary muscle both of which showed rece extensions. The aorta showed severe atheroscleros with numerous calcified intimal plaques and adhere mural thrombi. One of these plaques partially occlud the left renal artery and caused atrophy of the l kidney which weighed 60 gm. Atheromatous emb were found in the kidneys, spleen, pancreas, stomac small bowel, liver, urinary bladder, uterus, adren glands, and vertebrae. In the kidneys and spleen the were accompanied by small infarcts. In the descendi thoracic aorta was an aneurysm measuring 6 cm diameter which bulged from the anterior wall and co pressed the posterior wall of the midesophagus (Figu 2). The esophageal mucosa over this area was u cerated. At the same level as this ulcer on the posteri wall of the esophagus was a 3 cm perforating ulcer the anterior wall which extended into the posteri wall of the trachea just above the carina to create tracheoesophageal fistula (Figures 3 and 4). N esophageal diverticulum was noted and no enlarg perihilar lymph nodes were found.

On microscopic examination, the aneurysm showe thinning and destruction of the media with numerou large deposits of cholesterol crystals and a large mur thrombus. There was little or no inflammation, r granulomas or giant cells, and no evidence of en arteritis of vasa vasorum. The esophageal ulcer ar tracheoesophageal fistula showed superficial co onization by yeast-like organisms resembling *Ca dida* species which did not extend deeply into th tissue. At the margin of the ulcerated area were ra multinucleated epithelial cells with ground glass nu



Figure 3—Aneurysm and posterior wall of esophagus deflected to left revealing tracheoesophageal fistula involving anterior wall of esophagus.

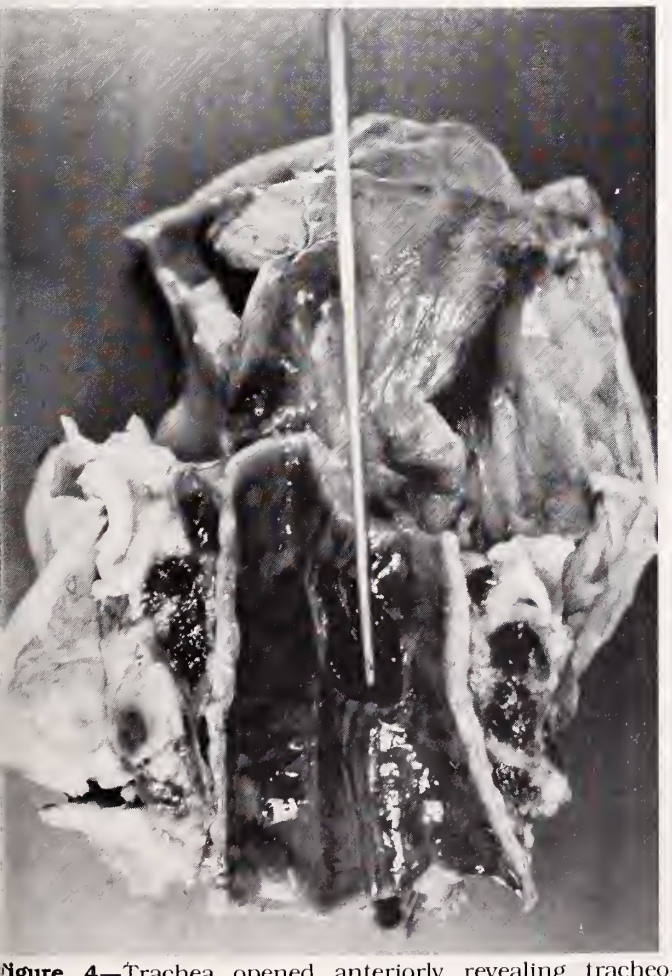


Figure 4—Trachea opened anteriorly revealing tracheoesophageal fistula involving posterior wall.

clei suggestive of herpesvirus infection. Inclusion bodies were not found. There was no evidence of tumor and the ulcerated areas displayed only necrosis and hemorrhage. A vein near the fistula contained an organized thrombus.

COMMENT

The kissing-type ulcers of the midesophagus occurring at the same level as the aneurysm of the thoracic aorta suggested that the ulcers were caused by repetitive collisions of the anterior and posterior walls of the esophagus due to pulsation of the aneurysm. Despite the presence of cells suspicious for tumor in the aspirated sputum, there was no evidence of neoplasm in multiple microscopic sections of the fistula. Most of the causes of acquired nonmalignant esophagorespiratory fistulas enumerated by Wychulis et al.[1] were not found. In particular, there was no clinical or pathologic evidence of tuberculosis, syphilis, actinomycosis, or diverticulum of the esophagus. In spite of the history of hiatus hernia, reflux esophagitis as a cause of esophageal ulcers and fistula is excluded by the location of the fistula in the midesophagus and the nonulcerated condition of the lower esophagus.

The presence of numerous *Candida* organisms in the fistula is a not unexpected finding in a diabetic patient treated with multiple antibiotics. These yeasts frequently colonize dead or dying tissue.

The presence of a few multinucleated giant cells with ground glass nuclei both in the sputum and autopsy sections of the fistula suggests herpesvirus infection. Herpetic esophagitis is a common cause of esophageal ulceration[4] and generally is regarded as an opportunistic infection occurring in debilitated patients particularly in those suffering from neoplastic disease and especially in the immunocompromised. However, esophageal trauma also has been recognized as a predisposing factor.[5] It is well known that cutaneous herpes infections have a predilection for traumatized areas[6-8] and tracheal trauma has been implicated as a predisposing factor in cases of herpetic tracheobronchitis and pneumonia.[9] In the esophagus, the trauma usually is from a nasogastric tube but there is no reason to exclude trauma caused by the pulsating aneurysm in this case. Concomitant herpes and monilial esophagitis previously have been reported.[4,10,11]

The few aneurysms of known cause that have been reported previously in association with tracheoesophageal fistulas have been caused by syphilis.[1,3,12-14] Unfortunately, a serologic test for syphilis was not performed in this patient. However there was no evidence of syphilitic aortitis and in particular no evidence of endarteritis of the vasa vasorum of the aorta, miliary gummas, aortic valvular insufficiency with widened commissures or stenosis of coronary artery ostia. The advanced age of the patient, the presence of severe generalized arteriosclerosis, and the pathologic features of the aneurysm speak for an arteriosclerotic aneurysm. Although arteriosclerotic aneurysms are more common in the abdominal aorta, 20 percent of such aneurysms are located in the thoracic aorta.[15] Several cases of dysphagia caused by esophageal compression by an aortic aneurysm [16,17] or a tortuous aorta[18] have been reported.

SUMMARY

Although dysphagia preceding an acquired tracheoesophageal fistula in an elderly patient suggests esophageal or bronchial cancer, in the absence of a tumor, the possibility of thoracic aneurysm as the cause of the fistula should be kept in mind.

REFERENCES

1. Wychulis AR, Ellis FH Jr, Anderson HA: Acquired nonmalignant esophagotracheobronchial fistula. *JAMA* 196:117-122, 1966.
2. Coleman FP, Burch GH Jr: Acquired nonmalignant esophagotracheobronchial fistula. *J Thorac Surg* 19:542-558, 1950.
3. Clagett OT, Payne JH, Moersch HJ: Acquired esophagotracheobronchial fistula. *Surg Gynecol Obstet* 82:87-90, 1946.
4. Nash G, Ross JS: Herpetic esophagitis, a common cause of esophageal ulceration. *Hum Pathol* 5:339-345, 1974.
5. Berg JW: Esophageal herpes: A complication of cancer therapy. *Cancer* 8:731-740, 1955.
6. Findlay GM, Mac Callum FO: Recurrent traumatic herpes. *Lancet* 1:259-261, 1940.
7. Stern H, Elek SD, Millar DM, et al.: Herpetic whitlow: A form of cross-infection in hospitals. *Lancet* 2:871-874, 1959.
8. Foley FD, Greenawald KA, Nash G, et al.: Herpesvirus infection in burned patients. *N Engl J Med* 282:652-6 1970.
9. Nash G: Necrotizing tracheobronchitis and broncl pneumonia consistent with herpetic infection. *Hum Pat* 3:283-291, 1972.
10. Rosen PR, Hajdu SI: Visceral herpes-virus infections patients with cancer. *Am J Clin Pathol* 56:459-465, 197
11. Mirra SS, Byran JA, Butz WC, et al.: Concomit herpes-monilial esophagitis: A case report with ult structural study. *Hum Pathol* 13:760-763, 1982.
12. Moersch HJ, Tinney WS: Fistula between esophagus and the tracheobronchial tree. *Med Clinics No Am* 28:1001-1007, 1944.
13. Davidson PB, Mills ES: Fistulae between the esophag and the respiratory tract. *Med Clinics North Am* 7:999-10 1923.
14. Dorner G: Broncho-oesophagealfistel bei aort aneurysma. *Dtsch Med Wochenschr* 39:400-401, 1913.
15. Blakemore AH, Voorhees AB: Aneurysm of the aorta review of 365 cases. *Angiology* 5:209-231, 1954.
16. Pezzella AT, Brown BE, Walls JT, et al.: Esophag obstruction secondary to a tortuous aortic aneurysm. C report. *Missouri Med* 78:193-195, 1981.
17. Sakiyalak P, Bellon EM, David P, et al.: Esophageal struction due to saccular aneurysm of the distal thora aorta. *J Thorac Cardiovasc Surg* 64:959-962, 1972.
18. Hanna EA, Derrick Jr, Dysphagia caused by tortuos of the thoracic aorta. *J Thorac Cardiovasc Surg* 57:134-1 1969.

BALANCED CALCIUM CHANNEL BLOCKADE!



Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

rdizem is indicated in the treatment of angina pectoris due to ronary artery spasm and in the management of chronic stable gina (classic effort-associated angina) in patients who cannot erate therapy with beta-blockers and/or nitrates or who remain mptomatic despite adequate doses of these agents.

ferences:
Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

Please see full prescribing information on following page.

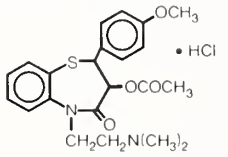
2/84

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+)-cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CAROIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), ras… asthenia (1.2%), AV block (1.1%). In addition, the followi… were reported infrequently (less than 1%) with the order of … tion corresponding to the relative frequency of occurrenc…

Cardiovascular:	Flushing, arrhythmia, hypotension, … dia, palpitations, congestive hea… syncope.
Nervous System:	Paresthesia, nervousness, som… tremor, insomnia, hallucinations, and…
Gastrointestinal:	Constipation, dyspepsia, diarrhea, … mild elevations of alkaline phosphata… SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photos…
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing ep… vasospastic angina developed periods of transient asy… asystole approximately five hours after receiving a sing… dose of CAROIZEM.

The following postmarketing events have been repo… quently in patients receiving CAROIZEM: erythema multif… kopenia; and extreme elevations of alkaline phosphata… SGPT, LOH, and CPK. However, a definitive cause and effec… these events and CARDIZEM therapy is yet to be establi…

OVERDOSAGE OR EXAGGERATED RESPONS…

Overdosage experience with oral diltiazem has bee… Single oral doses of 300 mg of CARDIZEM have been well … by healthy volunteers. In the event of overdosage or ex… response, appropriate supportive measures should be em… addition to gastric lavage. The following measures may be c…

Bradycardia	Administer atropine (0.60 to 1.0 mg… is no response to vagal blockade, a… isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fi… degree AV block should be treated … diac pacing.
Cardiac Failure	Administer inotropic agents (isopr… dopamine, or dobutamine) and diure…
Hypotension	Vasopressors (eg, dopamine or lev… bitartrate).

Actual treatment and dosage should depend on the seve… clinical situation and the judgment and experience of th… physician.

The oral/LD_{50}'s in mice and rats range from 415 to 7… and from 560 to 810 mg/kg, respectively. The intravenous … these species were 60 and 38 mg/kg, respectively. The or… dogs is considered to be in excess of 50 mg/kg, while leth… seen in monkeys at 360 mg/kg. The toxic dose in man is n… but blood levels in excess of 800 ng/ml have not been a… with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclero… nary Artery Disease or Angina Pectoris at Rest Due… nary Artery Spasm. Dosage must be adjusted to each … needs. Starting with 30 mg four times daily, before mea… bedtime, dosage should be increased gradually (given i… doses three or four times daily) at one- to two-day inter… optimum response is obtained. Although individual pati… respond to any dosage level, the average optimum dosa… appears to be 180 to 240 mg/day. There are no available dat… ing dosage requirements in patients with impaired renal … function. If the drug must be used in such patients, titration … carried out with particular caution.

Concomitant Use With Other Antianginal Agents

1. **Sublingual NTG** may be taken as required to ab… anginal attacks during CAROIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CAROIZEM may … coadministered with short- and long-acting nitrates, … have been no controlled studies to evaluate the a… effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS…

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of … 0088-1771-47) and in Unit Oose Identification Paks of … 0088-1771-49). Each green tablet is engraved with MARIO… side and 1771 engraved on the other. CAROIZEM 60-m… tablets are supplied in bottles of 100 (NDC 0088-1772-47) a… Dose Identification Paks of 100 (NOC 0088-1772-49). Ea… tablet is engraved with MARION on one side and 1772 on…

Issue …

Another patient benefit product from

PHARMACEUTICAL DIVISION
MARION LABORATORIES, INC.
KANSAS CITY, MISSOURI 64137

CLINICAL NOTE: GUIDED BLIND ENDOTRACHEAL INTUBATION

JAY JONG-IL CHOI, M.D., MARCELINO POTIAN, M.D., EUN YE YOO, M.D., WEN-HSIEN WU, M.D., NEWARK*

A modified method of blind endotracheal intubation used in a tracheostomized patient is presented. Advantages in simultaneous airway and ventilatory control without the use of muscle relaxants and without the need of an expensive flexible fiberoptic laryngoscope are described.

Insertion of a phrenic nerve pacemaker for a quadriplegic patient presents difficult prob-ns to anesthesiologists. The use of a guided blind dotracheal intubation technique is illustrated in a tient with pre-existing tracheostomy. We are de-ribing a modified Waters's technique[1] for intubation.

ASE REPORT

A forty-five-year old dependent quadriplegic patient th a tracheostomy of a one-year duration was sched-ed for insertion of phrenic nerve pacemaker. The tient had ankylosis of both temporomandibular nts with marked limitation of mouth opening (2.5). The cervical spine was markedly angulated (120°) the old fracture site.

A sterile suction catheter was inserted through the acheostomy stoma and oropharynx into the mouth. An endotracheal tube was threaded over the distal d of this catheter which served as a guide and ad-nced into the trachea while holding the proximal theter end at the stoma (Figure).

The bevel of the tracheostomy tube was reinserted rough the stoma for assisted ventilation. When the dotracheal tube was advanced to the level of the oma, the tracheostomy tube was removed, the en-tracheal tube was advanced further into the trachea, d the cuff was inflated and the airway was secured surgery.

DISCUSSION

It goes without saying that intubation in a patient with tracheostomy usually is performed through the stoma if needed.

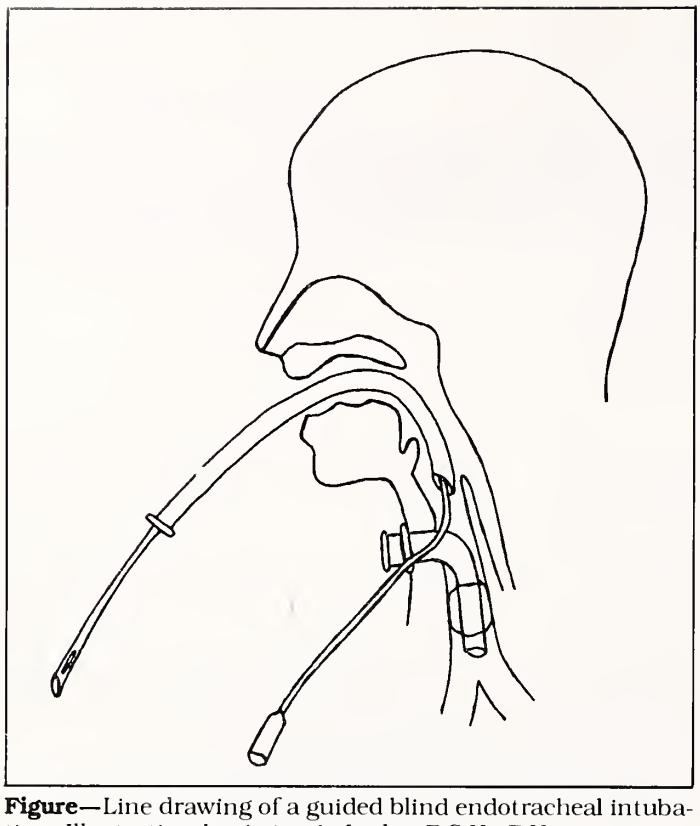
However, there are situations when oral or nasal intubation is needed with pre-existing tracheostomy.

A quadriplegic patient who requires insertion of a phrenic nerve pacemaker presents unique problems to anesthesiologists. The patient needs to remain conscious in order to respond to optimal pacemaker output. Muscle relaxants should be avoided to allow identification of the phrenic nerves and to prevent hyperkalemia from depolarizing agents. The technique of guided blind tracheal intubation which was first described by Waters[1] is as follows:

A wide-bore needle is inserted cephalad through the crico-thyroid membrane percutaneously. A thin polyethylene catheter next is passed through the needle and then advanced between the vocal cords into the nostril (or mouth). A tracheal tube is threaded over it and advanced into the trachea. Minor modifications of Waters's technique have been reported.[2-4]

The complications of guided blind endotracheal intubation were described by Akinyemi.[2] They included

*From the Department of Anesthesiology, UMDNJ-New Jersey Medical School. Correspondence may be addressed to Dr. Choi, UMDNJ-New Jersey Medical School, 100 Bergen Street, Newark, NJ 07103.



Figure—Line drawing of a guided blind endotracheal intubation. Illustration by Anita A. Lesko, B.S.N., R.N.

bleeding, breath-holding, respiratory obstruction, f ficulty in securing the distal end of the catheter using a hook, and loss of the hook.

We concluded that a modified Waters's technique tracheal intubation in the tracheostomized pati was extremely helpful. This method allows intubat and airway control through the tracheostomy t simultaneously. It does not negate the value of intu tion aided by a flexible fiberoptic laryngoscope.

SUMMARY

This modified method of blind endotracheal intu tion has advantages in simultaneous airway and v tilatory control without the use of muscle relaxa and without the need of an expensive flexible fiberop laryngoscope.

REFERENCES

1. Waters DJ: Guided blind endotracheal intubation patients with deformities of the upper airway. *Anaesthe* 18:158-162, 1963.

2. Akinyemi OO: Complications of guided blind dotracheal intubation. *Anaesthesia* 34:590-592, 1979.

3. Scurr C: A complication of guided blind intubati *Anaesthesia* 30:411-412, 1975.

4. Akinyemi OO, John A: A complication of guided bl intubation. *Anaesthesia* 29:733-735, 1974.

he IBM Personal Computer
tool for modern times
n the Medical Office.

EDI-SCAN®, an Authorized IBM® Value-dded Dealer for the Personal Computer

· Comprehensive $8,995.00 MEDI-SCAN In-office ing And Accounting System Includes:

ne IBM Personal Computer XT with 128K,) Megabyte hard disk.

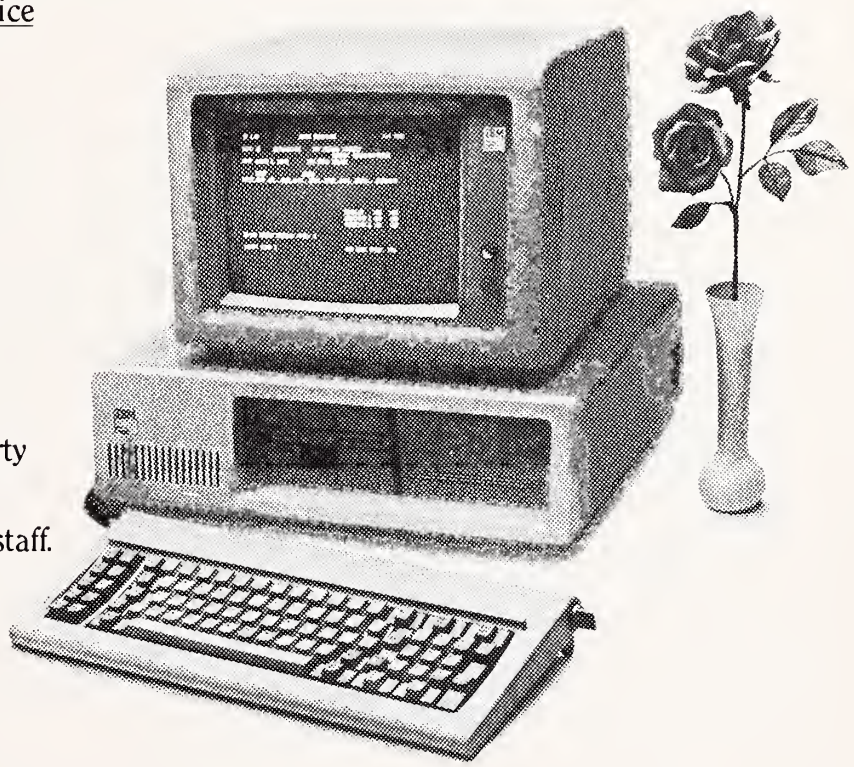
ne IBM Graphics Printer.

EDI-SCAN software—customized for your actice, including procedure numbers for state gencies. Generates accounting reports, mprehensive patient statements, insurance nd third party forms.

ptional electronic paperless billing to third party gencies, where applicable.

aining—Complete in-office training for your staff.

upport—"HOT-LINE" 800 number for ntinuous support.



EDI-SCAN Single Source pport System

DI-SCAN'S unique, comprehensive hardware and software maintenance agreement guarantees continuing vice and repair, system updates and additional customization, plus in-office training—all from one source. Our al training consultants and technicians are dedicated to giving you the best possible service.

M Personal Computer XTs are in stock in our local warehouses ready to be immediately installed. Over three ndred physicians are using the MEDI-SCAN System—join them in making the IBM PC-XT "A tool for modern es in the medical office."

Networking available for group practices and clinics

would like to know more about the MEDI-SCAN ystem on the IBM Personal Computer XT.

Dr. _____

Address _____

City _____ State _____ Zip _____

Phone (____) _____

Or call: 800-922-1021
In MA: 800-462-1009

Send to: **MEDI-SCAN**
90 Madison Street, Worcester, MA 01608

IBM Authorized Value Added Dealer Personal Computers

MEDI-SCAN

Service centers currently in: *New England* · *Mid Atlantic States* · *Mid Western States* · *California* · *Texas*

MEDI-SCAN is a registered trademark of PAL Assoc. Inc.
PAL Associates is an Authorized IBM Value-Added Dealer for the Personal Computer.
IBM is a registered trademark of International Business Machines Corporation.

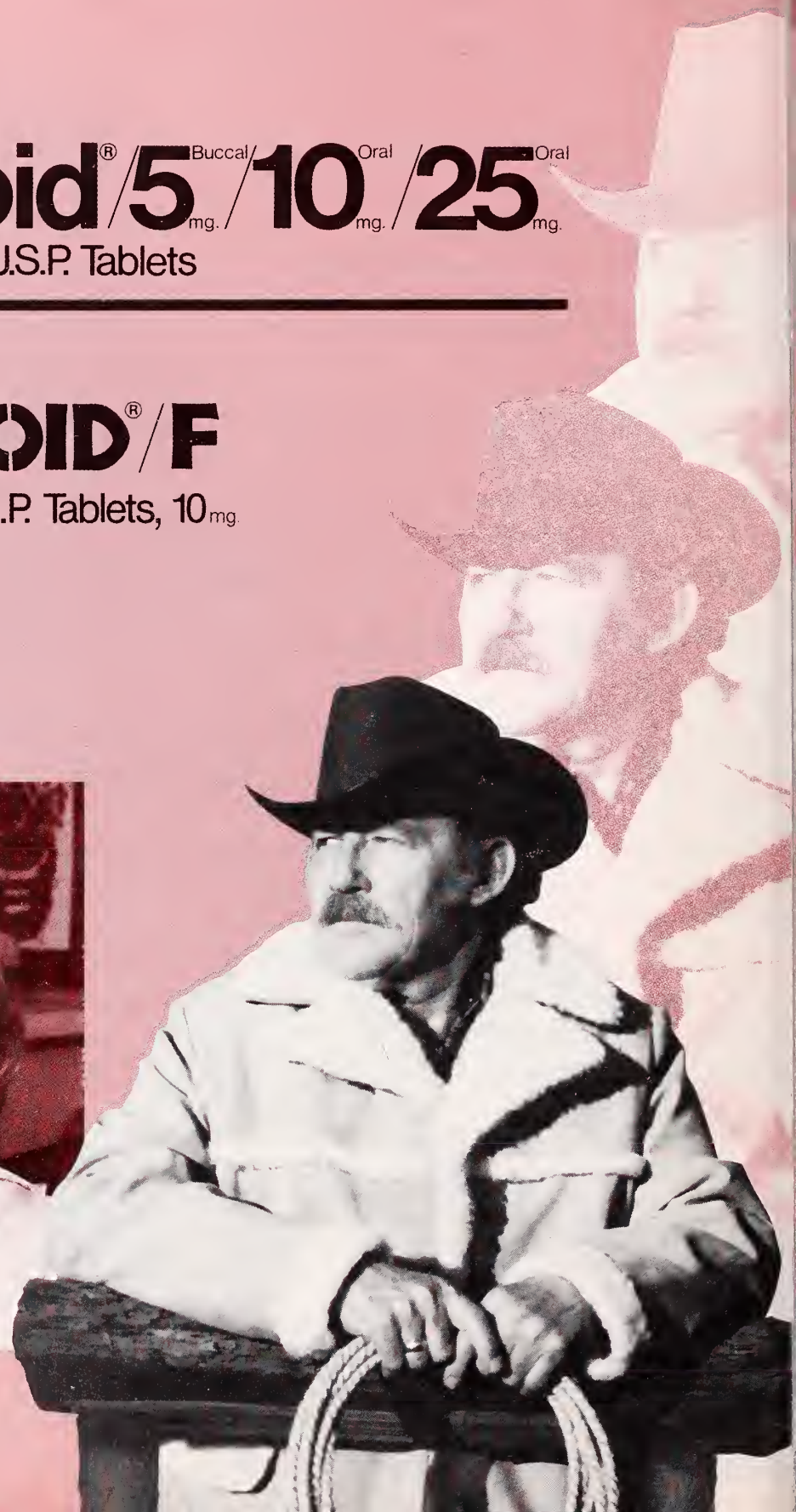
BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android®/5 mg. Buccal/10 mg. Oral/25 mg. Oral
Methyltestosterone U.S.P. Tablets

ANDROID®/F
Fluoxymesterone U.S.P. Tablets, 10 mg.





Clinical Note: Adverse Drug Reaction after Administration of Influenza Vaccine

Robert Solomon, M.D., and John Morlino, D.O., Union*
Mary Martucci, R.N., and Dolores Ney, R.N., Elizabeth**

The hepatic cytochrome P-450 enzyme can be impaired by influenza vaccine. This may cause altered drug metabolism and exaggerated side effects, especially in the elderly. Physicians should be aware of this problem and reduce the dosage or replace drugs which may be so affected.

The influenza vaccine is a recent and valuable addition to our medical armamentarium. Among the current recommendations for its use include vaccination of the elderly and those suffering from chronic illness. These two population groups have a high probability of receiving one or more medications on a regular basis and also have a higher than average incidence of adverse drug reactions.[1] Several articles describe the depressant effect of influenza vaccine on the drug metabolizing capacity of the cytochrome P-450 enyzme system.[2,3] This enzyme system is a key pathway for the metabolism of many medications.[4] The depression of functional capacity in the cytochrome P-450 system will result in high serum levels of medications metabolized via this system. The cytochrome P-450 system may function at reduced capacity for three weeks or longer after vaccination.[3] The cytochrome system is a major pathway for drug metabolism; hundreds of drugs are metabolized via this route and an abbreviated list appears in the Table.

Although the influenza vaccine has achieved moderately widespread use in the above-mentioned populations, many physicians are not aware of the potential adverse side effects, many with serious consequences that can occur in patients vaccinated while being maintained on medications metabolized via the cytochrome P-450 system. The following case presentation describes an adverse reaction occurring in a patient vaccinated while receiving a long-acting benzodiazepine.

CASE REPORT

An 86-year-old alert and oriented resident of a skilled nursing facility was administered 0.5 cc of trivalent flu vaccine. At the time of vaccination, his medications included digoxin 0.25 mg/po daily, furosemide 40 mg/po daily, ergoloid mesylates (Hydergine®) 1 mg/po t.i.d., and chlorazepate dipotassium (Tranxene®) 3.75 mg/po b.i.d. Two days postvaccination, he fell while ambulating down a corridor. Twelve hours later, a nurse found him sitting on the floor by his bed and noted that he was completely disoriented. He was transferred to a local emergency room where no traumatic injuries were noted on clinical examination. A skull x-ray, SMA6, and CBC were unremarkable. An ambulance brought him to our skilled nursing facility. On initial examination his rectal temperature was 99.2°, blood pressure 140/80, and respirations 22/minute and unlabored. Cardiac examination revealed atrial fibrillation. He was lethargic and disoriented to time, place, and person. There were no focal,

*From the Department of Medical Education Office, Memorial General Hospital, Union. Correspondence may be addressed to Dr. Solomon, Memorial General Hospital, Department of Medical Education Office, 1000 Galloping Hill Road, Union, NJ 07083.
**From Elizabeth Manor Nursing Home, Elizabeth.

neurologic findings. Ambulation was not attempted. The patient was continued on digoxin 0.25 mg/po daily and furosemide 40 mg/po daily. He received two additional doses of chlorazepate dipotassium (3.75 mg) before it was discontinued. Over the next six days, a dramatic improvement was noted in both his mental status and level of physical activity with the patient becoming both continent and ambulatory as he was prior to the occurrence of this episode.

DISCUSSION

There are many causes of confusion and lethargy in the frail elderly. The most likely cause in the case we presented is an elevated serum nordiazepam level. Chlorazepate dipotassium is decarboxylated in the stomach to form nordiazepam, its main active metabolite. Nordiazepam then is hydroxylated via the cytochrome P-450 system to form either oxazepam or p-OH nordiazepam, both of which are excreted by the kidney in the free as well as conjugated glucuronide form.[5] Unfortunately, we did not obtain a serum nordiazepam level to substantiate our hypothesis; however, based on the sequence of events, we feel the most likely explanation is the one offered above.

COMMENT

Physicians should be aware of the potential for adverse drug reactions in patients who receive influenza vaccine while being maintained on medications that are metabolized via the cytochrome P-450 system. These medications either should be redu in dosage or replaced by medications that bypass cytochrome P-450 system. In the case we deserib chlorazepate dipotassium could have been replaced oxazepam while retaining the desired drug effect.

TABLE

Abbreviated List of Medications Metabolized Via Cytochrome P-450 System

Alprazolam	Tricyclic antidepressants
Barbiturates	Flurazepam hydrochlorid
Chlorazepate dipotassium	Meperidine
Chloridiazepoxide	Meprobamate
Diazepam	Phenothiazines
Digitoxin	Phenytoin
Theophylline	Quinidine

Warfarin

REFERENCES

1. Ouslander JG: Drug therapy in the elderly. *Ann Int Med* 95: 711-722, 1981.
2. Kramer P, McClain CJ: Depression of aminopyr metabolism by influenza vaccination. *N Engl J M* 305:1262-1264, 1981.
3. Renton KW, Gray JD, Hall RI: Decreased eliminatior theophylline after influenza vaccination. *CMA J* 123:288-2 1980.
4. Remmer H: The role of the liver in drug metabolism. *J Med* 49:617-629, 1970.
5. Abbott Drugs: Tranxene® (chlorazepate dipotassiu Drug Monograph.

Doctors: Write your own prescription to cure insurance pains . . .

℞ Prescription

lame MSNJ Member

MSNJ Group
Blue Cross/Blue Shield
Major Medical and
Dental Insurance

that provides:

- **Flexible plans**
- **Comprehensive benefits**
- **Low, competitive rates**
- **Centralized Administration**

Designed and Administered by
DONALD F. SMITH & ASSOCIATES

℞ Prescription

Name _____

Address _____

Phone _____

Please send more information on the MSNJ

- ☐ Blue Cross/Blue Shield Program
- ☐ Major Medical Program
- ☐ Group Dental Program

Return to:
Donald F. Smith & Associates
One Airport Place, Route 206 North
P.O. Box 2197,
Princeton, New Jersey 08540
(609) 924-8700, (201) 622-6046

Medical History: Conversations in Medicine*

Allen B. Weisse, M.D., Newark**

A visit to the author's place of training provided stimulation for a book about the 20th century advances of medicine. Interviews with 16 outstanding physicians, scientists, and teachers, constitute the results of a five-year endeavor.

It all began in the spring of 1978 when I was invited back to the University of Utah College of Medicine by my former colleagues to give several lectures on the cardiovascular research we had been performing at UMDNJ-New Jersey Medical School. As I prepared for these presentations, there gradually dawned upon me the opportunity for another kind of experience at the institution where I had received my training in cardiology over a two-year period beginning in 1961.

Since I left Utah, clinicians and basic scientists who learned of my experience there asked me about two of the medical giants who made that institution world renowned. They were the hematologist and chairman of the department of medicine, Maxwell M. Wintrobe, and the pharmacologist, Louis S. Goodman, who put Utah on the medical map and was instrumental in establishing pharmacology as a discipline in its own right through his research and the famous textbook he coauthored with Alfred Gilman.

Unfortunately, I was hardly in a position to know what Wintrobe and Goodman were like. Wintrobe headed the department of medicine of which I was a member as a cardiology fellow, but most of the junior physicians in the department were more interested in maintaining a comfortable distance from Wintrobe than coming under close scrutiny by him. He was well known for his withering criticism when performance did not match up to his exacting standards. Being in cardiology rather than general medicine or hema tology, I kept a low profile vis à vis the chairman fo the two years I was there. The price I paid was tha I scarcely knew him.

My contacts with Goodman were even more remote He was the head of a basic science department whil I was in clinical medicine. My total knowledge of Good man derived from glances at official functions an admiring reports I received from a Ph.D. candidate i pharmacology who rented rooms in the same buildin as I.

On the eve of my departure for Utah, I began to lool forward to the opportunity it would give me to mee and chat with these great medical figures, as a "visit ing fireman." I then would make up for my past defi ciencies, at least in part. Simultaneously, I was seize with the thought that many people in and out of medi cine might like to learn how such major figures, in the twilight of their careers, looked upon their years o struggle and accomplishment.

*Adapted from a talk presented to the New Jersey Historica Society. *Conversations in Medicine: The Story of Twentieth Century American Medicine in the Words of Those Who Created It* was published by New York University in June 1984.

**Dr. Weisse is Professor of Medicine, UMDNJ-New Jersey Medical School. Correspondence may be addressed to Dr Weisse, UMDNJ-New Jersey Medical School, 100 Berger Street, I-576, Newark, NJ 07103.

t was not until the early part of this century, es-
cially in the years preceding and following World War
I that American medical science emerged from being
medical backwater in the shadow of European sci-
ce. During those years, Wintrobe, Goodman, and
hers helped usher in the era of American medical
e-eminence. Who would not be moved by the per-
nal stories of these leading figures in this develop-
ent? These thoughts stimulated me to write a book,
nversations in Medicine, in which I attempt to re-
e this tale through the recorded recollections of
ese major figures, bridging their individual accounts
th the medical and social history of the period in
hich they worked.

Since we had so many roots in European medicine,
had to include some individuals whose backgrounds
ould bring this to light. In medicine, I thought of my
rmer mentor at the State University of New York in
ooklyn, the cardiologist, William Dock. Not only had
trained in Vienna, but he was the son of the first
ll-time medical department chairman in the United
ates, George Dock, a protégé of Osler. William Dock
so was well grounded in pathology, the foundation
on which the advances of medicine within this cen-
ry initially were based.

In surgery, the University of Minnesota's Owen H.
angensteen, dean of American surgery for so many
ars, was the obvious choice. It was he who did so
uch to bridge the gap between physiology and
inical surgery. He was well acquainted with the
atus of European surgery at that time and had per-
nal knowledge of all the great American surgeons
om the Mayos and Harvey Cushing and beyond. He
so was a medical historian.

What about the rest? I felt that the choice of con-
ibutors best could be guided by the major develop-
ents of the period: 1) the growing understanding of
e formation of the blood elements (hematology) and
e importance of nutrition within this scheme; 2) the
dvances in pharmacology: antibiotics for infectious
iseases and useful drugs for the treatment of
rdiovascular disease; 3) the development of heart
urgery; 4) the expansion of knowledge about im-
unology and cancer; 5) the beginnings of organ
ansplantation and artificial organs; and 6) the dis-
overy of the chemical configuration of DNA and the
irth of molecular biology.

In the first decades of this century, laboratory medi-
ine was brought to the bedside largely by hematolo-
ists. Wintrobe's accomplishments make this ap-
arent. Preceding this, however, and firing the im-
gination of physicians everywhere was the discovery
f the role of nutrition in the formation of the blood
ells. This was exemplified best by the work of George
. Minot and William Parry Murphy in the liver treat-
ent of pernicious anemia for which they shared a
obel Prize in Medicine with George H. Whipple of
ochester in 1934. Dr. Murphy was the last surviving
ember of this triumvirate and although debilitated
y age and illness, he welcomed my visit to his home
n Brookline, Massachusetts.

Goodman's career touched much of the progress in
harmacology, which included the introduction of
ntibiotics for the treatment of infectious diseases.
his triumph can be appreciated best through the eyes
of one whose career had spanned the era preceding the introduction of antibiotics and the years through which their utilization has flourished. Boston's legendary Louis Weinstein was the obvious choice here.

For heart surgery, I wanted to turn to someone who was there at the beginning. The first major attempt to deal surgically with intrinsic disease of the heart itself involved the introduction of the closed mitral commissurotomy for mitral stenosis. Charles P. Bailey, Dwight D. Harken, and Sir Russell Brock all shared in this accomplishment. Bailey, a New Jerseyan, however, had the slight edge of priority and offered the additional advantage of his postsurgical career. He had turned to law following surgery and had become an expert in medical malpractice, one of the most disturbing recent problems to the profession.

The growth of heart surgery demanded an expansion of our knowledge about cardiovascular physiology in man, which could be learned only through the development of cardiac catheterization techniques. This naturally led to the second Nobel Prize Laureate in the book, André Cournand, who shared this award with Dickinson Richards and Werner Forssmann in 1956.

More recent general advances in surgery could best be addressed by Harvard's Francis D. Moore who headed the surgical department at the Peter Bent Brigham Hospital for a 30-year period beginning in 1948. His knowledge of medical manpower problems and the Boston medical scene were added bonuses.

In order to get an outsider's view of American medicine during this period, I visited Sir George Pickering at Oxford. Pickering had a very active career as a researcher in hypertension and as an educator. During the course of his career, he visited almost every major medical school in America. He was well versed in what we did well and what he felt we did badly. He also was an expert on Great Britain's National Health Service and had a contrasting view to present on the proper role of government in medicine compared to that espoused by his counterpart, Moore.

With a view to more recent developments in American medical science and what they portend for the future, I turned to Robert A. Good, at 62 the youngest of those appearing in the book. His personal career in immunology and cancer research has encompassed almost every major development in the field over the last 40 years. Good had an additional element of interest: his shattering experience at Sloan-Kettering during the Summerlin mouse-painting episode 10 years ago. This provided an opportunity to discuss medical ethics and lessons learned about potential fraud in research.

No single individual has been more involved in the development of artificial organs than Willem J. Kolff, developer of the first practical artificial kidney. He also has been the force behind the development of the artificial heart, ventricular assist devices, and artificial eyes, ears, and limbs.

We now know the future of medicine lies at the level of the gene in the world of biochemistry. To enlighten us on the growth of this field through his own experiences and to point the way to the future I turned to Dr. Arthur Kornberg, the final Nobel Prize recipient in the group who was known for his work in DNA replication and other aspects of molecular biology.

In addition to the strictly scientific aspects of American medical progress, I wished to reflect the changing relationship between organized medicine and such groups as blacks, women, and Jews. Fortunately, I was able to enlist the cooperation of several individuals who were prominent scientists and educators despite the restrictive prejudicial atmosphere of the time.

Joseph L. Johnson served as either dean or head of the physiology department at Howard University's medical school for over 30 years until his retirement in 1971. Marian Ropes, the first woman medical resident at the Massachusetts General Hospital, has achieved wide recognition as an authority in rheumatological disorders, especially lupus erythematosis. New Jersey's Dr. Lena F. Edwards started her medical life with three strikes against her: a woman, a black, and an interest in obstetrics, a specialty whose members were reluctant to accept women. In addition to becoming one of the first black women to become board certified in obstetrics and gynecology, she was a pioneer in the introduction of community involvement in the delivery of medical care through her leadership in the construction of a migrant workers' maternity hospital in Hereford, Texas, in 1961.

Who would not be moved by the stories of leading figures in the development of American medical pre-eminence?

The mechanics of this oral history project may interest the reader. After gaining the acquiescence of an individual, I obtained a copy of his or her curriculum vitae and bibliography. Prior to the interview, I absorbed as much background material as possible and then contacted the subject's medical contemporaries, friends, and relatives to ferret out the most fruitful avenues of interrogation. By the time of the interview, I felt well prepared to get the most out of the allotted hour or two; in some cases, a second meeting was arranged.

The taped material was typed, edited, and rearranged to achieve a coherent and meaningful form before submitting the polished version to the interviewee for final approval. It was my assurance that no chance remark that might prove embarrassing would appear that achieved the trust and openness vital to every story. A few items fell by the wayside as a result (one contributor had the endearing but disconcerting suspicion that almost every other paragraph might constitute grounds for libel action) but no essential information was sacrificed to discretion. In several instances where I thought this might prove to be the case, I was able to convince my interviewee about the importance of the material which wound up in print.

The first interview took place in March 1978 and the final one in April 1983. At the conclusion of this work, I felt confident that the 16 life histories that I had included would provide a representative panorama of American medical history during this period, but I also realized that some personal bias had been inescapable in the selection process. Colleagues who learned of this project invariably came up with suggestions for t or that individual who, for various reasons, could be included. Several areas of progress, endocrinol and metabolism, were underemphasized because the deaths or illnesses of those whom I would h approached. Personal reasons also intruded. In instance, the person whom I had considered the m outstanding woman physician of this time, worldw ultimately refused to cooperate despite a year pursuit on my part.

Such omissions notwithstanding, I believe the o inal purpose of the book was achieved. As the fi lines were written, I was tempted to draw some br conclusions from the personal histories I h gathered. Although the method of selection undenia was idiosyncratic and never would stand up to a kind of statistical analysis, there were some obviou broad strokes of character and experience here tha felt compelled to acknowledge.

The sample of women obviously was too small to representative; it is sufficient to note that they all h to be exceedingly bright, determined, and lucky achieve prominence in their selected fields.

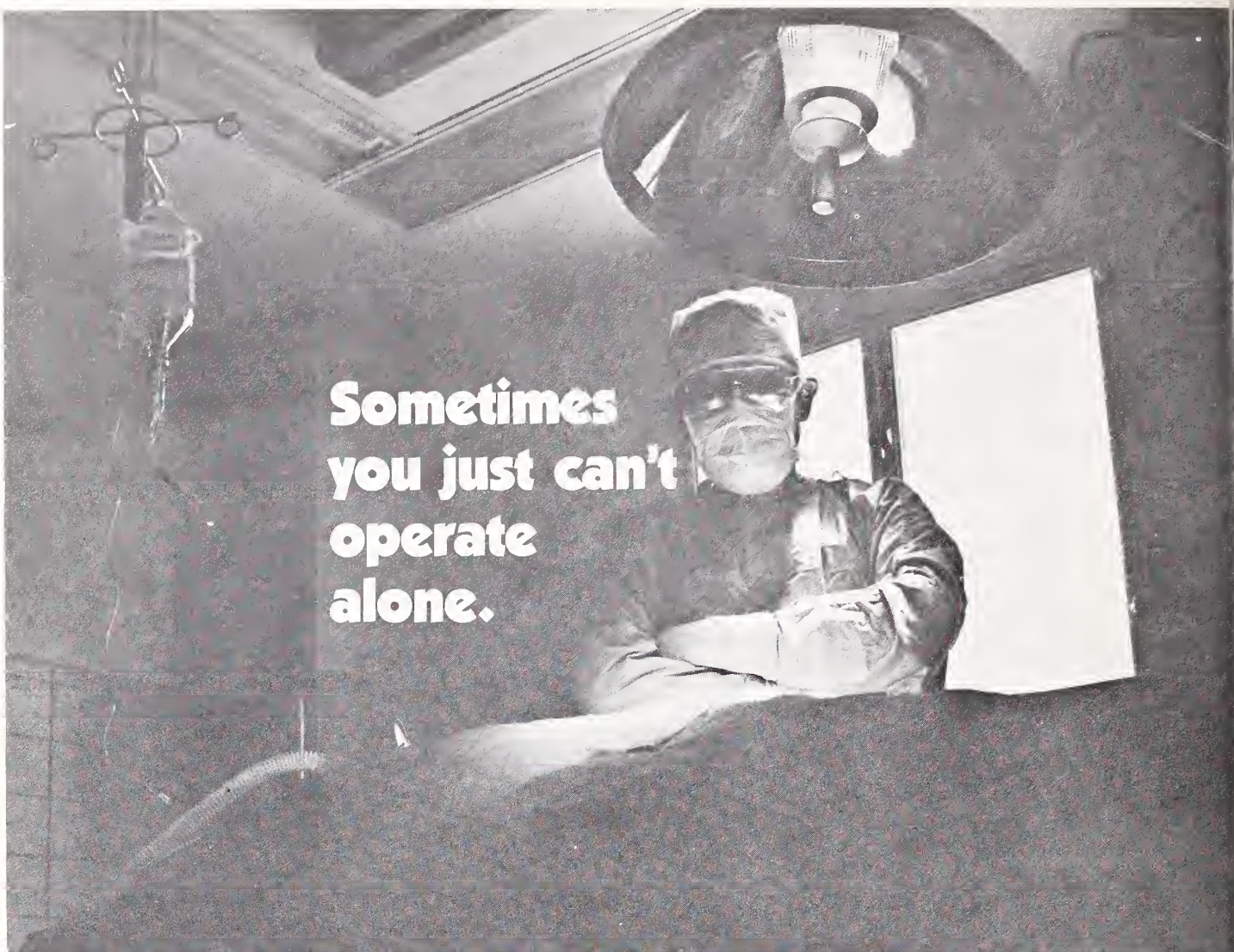
Among the men, certain common attributes w striking. The first requisite for success seemed to a father who was dead, distant, or indecisive in ter of providing guidance. Bailey, Pickering, Johnson, a Good were all deprived of this role model in th youths by the untimely deaths of their fathers. In oth instances, there seemed to be an emotional separati between father and son. Only André Cournand, in t course of our talk, touched on a paternal influence th seemed truly profound. As striking as the absence fathers was the presence of strong-willed encouragi mothers. Without them, it is doubtful that many of t men would have persevered as they did.

Poverty also seemed to be a necessary spur for ma of these men. It runs like a leitmotif through many their stories. Interestingly, this did not serve as a incentive to become wealthy but provided a rigorou exercise in preparation for the other future hardshi they would have to face. Racial, religious, and sexu discrimination are aspects of medicine that are gro ing less and less prominent in modern American s ciety but they were an unquestionable part of the pa as reflected in the experiences of some of those wit whom I spoke.

What about the tradition of medical families? U questionably, there are distinguished families of ph sicians from one generation to the next: the Mayos, th Warrens in Boston, and others. But, these probably a exceptions to the rule. Among those I interviewed on Dock and Kolff had physicians as fathers (Lena Ed wards' father was a dentist) and only Dock's father wa pre-eminent in his field. I found it comforting to con clude from this that in a democratic society outstand ing physicians can arise from any background.

Finally, I thought of my own children and wondere if they would follow in my footsteps or go beyond then As much as we all profess an attitude of support an encouragement for the career goals of our offspring whatever their direction, a certain desire to se another physician in the family always is there. Medi cine is a wonderful profession. But, after noting th characteristics of my own selection of medical greats

ooked with some bemusement upon the "disadvan-ged" background of my own two teenagers. Both of ir parents are alive, well, and members of the medi- profession. As a result, their economic resources for furthering of their education, although not ex-vagant, are certainly more than adequate for the k. They attend a suburban school system that is tstanding, especially in its recognition and catering gifted children. They live in a social milieu in which tors of discrimination, which they might have faced in the past, have been minimized greatly if not totally obliterated. With all this going against them, I asked myself, tongue-in-cheek, if any source could provide them the necessary spur for achievement in medicine—or any other field of endeavor for that matter. One day they may read this book. Learning about this extraordinary group of men and women may inspire them to accomplish whatever is potentially within their grasp. After all, what more can we ask of our sons and daughters, our students, and ourselves?



When it comes to saving lives, teamwork becomes not only desirable; it becomes necessary.

In an operating room, in an emergency room, in consultation with other physicians, teamwork helps you do your job to the best of your ability.

The American Medical Association and your state and county medical societies believe in the value of teamwork — and the necessity of it, in the face of an increasingly complex professional environment.

We also believe that medical societies have certain tasks that the individual physician couldn't possibly assume — and shouldn't have to.

For example, to keep government regulations from interfering with your practice, we effectively represent your interests at local and national levels.

To influence policies of organized medicine with which you disagree, we provide the means to have your views heard and respected.

And to keep you up to date on the latest medical advances, we publish JAMA, AM News, specialty, state, and county journals.

In fact, for all the times you can't operate alone, your medical societies will be there. Working with you to defend your rights and protect your freedoms.

Join Your Medical Societies Today.

For more information, contact your county or state medical societies, or call the AMA collect at 312/751-6196. Or return the coupon below to your state or county medical society.

☐ Please send me information on AMA, county, and state society membersh

☐ I am a member of my county and state societies; please send me informat on joining the AMA.

Name _____

Street _____

City _____ State _____ Zip _____

County _____

CURRENT NUTRITION: PROGRESS IN FOOD ALLERGY AND FOOD SENSITIVITY*

RICHARD N. PODELL, M.D., NEW PROVIDENCE**

Claims about food sensitivity are flawed by their reliance on anecdotal testimony.[2-5] Despite this discouraging history there has been a revival of serious interest in food sensitivity. Although the number of controlled studies is too small for firm conclusion, several recent reports support the view that food sensitivity may be much more important than usually is credited.

More than 2,000 years ago Hippocrates proposed that idiosyncratic reactions to food were a major cause of illness.[1] This and most other claims about food sensitivity are flawed by their reliance on anecdotal testimony.[2-5] Most physicians have been reluctant to accept a major role for food sensitivity.[6,7] Despite this discouraging history there has been a revival of serious interest in food sensitivity. Although the number of controlled studies still is too small for firm conclusion, several recent reports support the view that food sensitivity may be much more important than usually is credited. This paper provides a selective review and analysis of current research.

May and his colleagues at Denver's National Jewish Hospital deserve credit for being the first to apply systematically modern scientific double-blind research methods to the study of food sensitivity.†[8,9] May studied 38 children with asthma whose parents and physicians believed that their child's asthma was made worse by the ingestion of specific foods.[8] The children were hospitalized and fed the suspect foods, or a placebo, which were hidden in an opaque capsule. Positive reactions after feeding the suspect food occurred in only 14 of 38 children and for only 14 of 70 suspect foods. Usually, only gastrointestinal symptoms resulted and none suffered an acute attack of asthma. In every case where the food challenge was positive, the skin prick test was positive. However, the skin prick test also was positive in many instances in which clinical sensitivity could not be confirmed by the feeding challenge.

The following conclusions have been inferred:[6,9]

1. Although food-induced asthma can occur, it probably is rare since only a few of these carefully selected patients reacted at all after feeding and clinical asthma was not induced in any.

2. A positive history of food-induced asthma is unreliable and is more likely to be false than true.

3. A negative prick test probably rules out significant food sensitivity, but a positive prick test does not predict reliably that a patient is clinically sensitive.

In short, significant food sensitivity is unlikely even when the history and skin prick tests are positive. A

*This column is prepared under the direction of Herman Baker, Ph.D., Professor, Preventive Medicine/Community Health and Medicine, UMDNJ-New Jersey Medical School.

**From the Department of Family Medicine, UMDNJ-Rutgers Medical School, Piscataway, where Dr. Podell is Clinical Associate Professor. Correspondence may be addressed to Dr. Podell at 29 South St., New Providence, NJ 07974. This paper was presented in the Allergy, Immunology, and Infectious Diseases Lecture Series, United Hospitals Medical Center, Newark, December 8, 1983.

†The term sensitivity is preferred when the mechanism of an idiosyncratic reaction is unclear or when it is unrelated to an IgE mechanism. The term allergy should be restricted to instances in which reagenic antibody (usually IgE) is believed to be important.

suspicion of food sensitivity almost always will prove false if the skin prick test is negative.

This interpretation has been accepted by most authorities,[6-9] but not by all.[10] The critical issue is whether the particular oral food challenge protocol used by May is, in fact, a valid and sensitive measure of clinical sensitivity to foods.

Surprisingly, there have been no independent systematic controlled assessments of the reliability and validity of May's oral food challenge protocol or of the other popular protocols for diagnosing food sensitivity.[2,4,11] Critics of the May protocol argue that it is likely to underestimate the prevalence of food sensitivity.

May discussed one pertinent issue: that there was an extremely high prevalence of skin test positivity among subjects who had a positive history and a negative food challenge. Although only 10 of 56 cases with negative food challenge had a positive prick test to the suspect food, 52 of the 56 had positive skin tests if the more sensitive intradermal tests were included.[9-11] Such a high correlation between history and skin test results would not be expected if the positive history were based on a placebo effect.

May interpreted these as instances of "asymptomatic hypersensitvity." He argued that the subjects were biologically allergic to the suspect foods, but not enough for the allergy to be clinically meaningful. However, these facts also are consistent with another possibility: that the history and skin test results were both meaningful, but that May's particular oral food challenge protocol was not sensitive enough to demonstrate it.

Several reasons why the May protocol might be a weak one have been advanced. For example, because May placed the test foods in small opaque capsules, challenge meals rarely were larger than one-third of an ounce. Larger challenges or repeated challenges at consecutive meals might have elicited greater clinical reactions.[11]

According to some authors the duration of abstinence before challenge may critically affect results.[4,5] Thus Rinkel argued that clinical sensitivity to a commonly eaten food often decreased after a month or so of abstinence.[4] Therefore, oral challenges should be done within a few days to a few weeks after the suspect food is omitted from the diet. In contrast, May required his subjects to be off the suspect food at least two weeks. However, May provided no data on the actual duration of abstinence before challenge. Since the parents and physicians of subjects felt strongly that the test foods triggered asthma, it is not at all farfetched to imagine that many of the children with negative oral food challenge had been off their suspect foods for many weeks or months before the negative challenge. Although one cannot answer with certainty, several recent studies suggest that the May protocol may underestimate the prevalence of clinical food sensitivity.

ASTHMA

A recent Danish study suggests that dietary factors adversely affect a substantial proportion of seriously ill asthmatics. Hoj et al. studied 41 consecutive hospitalized asthmatics, who were allocated double blind to one of two diets.[12] One was a defined elemental formula diet, thought to be hypoallergenic.[13] The other was normal hospital diet. Both were liquified and swe ened so as to be similar in appearance and taste. Me cal treatment was done in the usual way and outcom were assessed by a predetermined formula based pulmonary functions and medication taken during t last *v* the first four days of the two-week trial peri

Overall, patients on the elemental diet did substa tially better than those eating the hospital diet. Ni of the 21 subjects completing the elemental diet i proved according to the preset criteria; none teriorated. Only 1 of the 16 hospital diet subjects i proved and 5 subjects deteriorated. The difference outcome scores was statistically significant (P <.05). The 9 elemental diet patients who improv substantially had no higher frequency of positive sk prick tests to common foods than did the 12 patien whose condition remained stable. The authors co cluded that a trial of elemental diet is justified for perennial asthmatics even when there is little eviden of extrinsic etiology. This study has several limitatio including small numbers of patients and the difficul in disguising the taste of an elemental diet. Howev the major concern is the relatively poor results for t control group subjects. This suggests that much most of the benefit attributed to the elemental formu diet actually might be an artifact due to the atypica poor outcome of control group subjects. It is extreme disappointing that no attempts to replicate this i portant study have yet appeared.

MIGRAINE

It is surprising that migraine, a condition n thought of as "allergic," is the focus of a number reasonably well-designed food sensitivity studies. T most important is a report from the pediatric migrai clinic at the Hospital for Sick Children in London. Eighty-eight children with severe, at least weekly, m graine completed a three- to four-week period in whi their diet was limited to one meat, one starch, one fru one vegetable, water, and vitamins. During the last tw weeks of this elimination diet, 78 subjects had headaches, 4 patients were rated as improved, and on 6 patients were not improved. Foods were added ba one at a time. Each new food was taken in multip servings for a week or until migraine recurred. Th continued, apparently for many months, until a socia ly and nutritionally acceptable diet was achieved.

Among the 82 subjects who improved after t elimination diet, 74 subjects relapsed after challeng to an average of 2.7 foods each. The key question w whether these apparent "reactions" were specific whether placebo effect or other nonspecific facto were responsible. Curiously, at the start of the stud four of the five authors believed that food-associate migraine was basically a placebo effect. They were su prised when the data confounded their expectation

Forty subjects were selected for two double-blin challenges. For one week, each ate a placebo food— paste of strongly sweet or sour nonsuspect food. F another week they ate a suspect food, which was di guised by blending it into the placebo. Headaches related symptoms occurred much more often durin the week of eating the suspect foods. Thus, 28 subjec reacted only with the suspect food and only 2 subjec

eacted only after the placebo. Four subjects reacted fter both, and 2 subjects after neither. Thirty-five subects preferred the placebo and only 2 subjects referred the suspect food. The differences statistically re significant ($P<0.001$), confirming that most of the ubjects were specifically sensitive to the foods that ppeared to provoke their headaches. There appears to e no serious criticism of the study's essential validity. lowever, the severity and complicated nature of these hildren's illness may make them unrepresentative of he migraine patients seen in more general practices. hese findings are yet to be confirmed independently. lowever, for now, the preferred conclusion must be hat there is a population of children with migraine-ke illness in which food sensitivity plays a critical ole.

This study also confirms May's observation that ositive skin prick tests often are false positives: 58 ercent of the positive skin-prick tests could not be onfirmed by oral food challenge. However, contrary to lay who found no false negative prick tests, 75 per-ent of the foods which appeared to provoke migraine fter oral challenge gave a negative prick test. This mplies that food sensitivity in migraine is largely not gE mediated or that the IgE is not detectable in the sual ways. For example, the specific IgE might be ocalized to the gut or might be directed against a etabolic product of the food rather than at the food self. In any case, skin prick testing appears to be of ttle value in predicting food sensitivity in migraine.

Specific food sensitivity is likely to prove important in migraine, eczema, irritable bowel syndrome, and asthma.

The most important conclusion may relate to the alue of different oral food challenge protocols. The igraine study challenged large amounts of food re-eatedly. On the average it took two days for food hallenges to induce headaches (range: less than one our to more than seven days). Had May's protocol for ral food challenge been applied, it would have failed detect the large majority of instances of clinical nsitivity. Even the more vigorous Rinkel challenge rotocol probably would have been less sensitive than he heroic protocol used by the London investigators. his result casts doubt on the validity of the May oral hallenge protocol as the definitive method for the iagnosis of food sensitivity. Therefore, it forces the opening of all issues which were decided based on lay's methodology.

Several studies suggest that food sensitivity also has n important role in adult migraine. However, two udies are flawed by their failure to use double-blind chnique.[14,15] One appears to be satisfactorily con-olled.[16]

Another intriguing experiment recently was re-orted. It suggests a possible nonimmunologic mech-nism for food-induced migraine.[17] It was found that atients with a history of diet-induced migraine had lower platelet levels of an enzyme known as phenolsulphotransferase-P (PST-P). Both healthy controls and migraine patients whose headaches were not induced by foods had normal levels. PST-P may have a role in the detoxification of phenolic compounds, which are common in foods and in food additives. If this finding is confirmed and if PST-P levels also are decreased in the gut and/or other pertinent organs, then a plausible nonimmunologic mechanism for diet-induced migraine could be postulated.

ECZEMA

Although dermatologists tend to be dubious, allergists long have argued that eczema contains important elements suggestive of an allergic condition. High levels of IgE in serum are common and there is a substantial association with other allergic diseases such as asthma and seasonal rhinitis. Recent reports now provide fair, but not conclusive, evidence that elimination diets are helpful in treating eczema,[18-20] good evidence that sensitive foods can provoke pruritis and rashes after oral challenge[21] and fair evidence that sodium cromoglycate, a mast cell stabilizer, is effective in eczema when taken orally.[22] Taken together these studies suggest an important role for food sensitivity among some patients with eczema. (Two new double-blind studies also support a link between food allergy and eczema.[63,64])

IRRITABLE BOWEL SYNDROME

That food allergy and sensitivity can provoke gastrointestinal symptoms in children or that gluten sensitivity occurs in children and adults is not in dispute.[23-25] Recent evidence that gluten enteropathy is a multisystem disease also is reasonably well based.[26-30] What has been controversial, though, is whether that most common of all intestinal problems, irritable bowel syndrome, also results in part from sensitivities to specific foods.

Two recent double-blind studies support the view that specific food sensitivity is important in some patients with irritable bowel syndrome. Alun-Jones et al. placed 21 subjects with diarrhea and painful type irritable-bowel syndrome on a modification of the Rinkel elimination/challenge protocol.[31] After one week on a diet limited to one meat, one fruit, and spring water, 14 of the 21 subjects were clear of symptoms. Open challenge with individual foods and three subsequent repeat challenges implicated one or more foods as specific triggers. The most common were wheat (9 persons), corn (5), dairy (4), coffee (4), tea (3) and citrus (2). In all cases of wheat intolerance, small-bowel biopsies were normal.

Six patients received double-blind challenge of either suspect foods or a nonsuspect placebo. These were liquified and fed through a nasogastric tube. Reactions occurred after the suspect food 10 of 12 times and after the placebo food only 1 time in 12 ($P<0.01$). Five additional subjects were tested single blind and correctly identified the test food and the placebo in each of ten challenges.

Bentley, Pearson, and Rix did a similar study, although their elimination diet appears not to have been rigorously enforced.[32] Although a high proportion of subjects improved during the elimination phase,

double-blind challenge using the capsule technique disclosed that only three of eight subjects tested could repeatedly distinguish test foods from placebo. As might be expected substantial psychopathology was demonstrable among these irritable bowel patients.[33] However, this was true among both those passing and those failing the double-blind verification challenge.

Although the two studies differ in the proportion of subjects who could distinguish suspect foods from placebo, both document that food sensitivity occurs in a significant proportion of irritable bowel patients. Since these studies used different elimination and challenge techniques, some of the differences in results may derive from their different testing methods. These differences emphasize the critical need for validating an acceptable "gold standard" for the diagnosis of food sensitivity.

CONCLUSIONS

Although there was little well-controlled scientific evidence of an important role for food sensitivity before the 1980s, several respectable studies favoring such a role have appeared in the last few years. Their number still is too small for definitive conclusions; however, they do provide credible support for the view that specific food sensitivity is likely to prove important in migraine, eczema, irritable bowel syndrome, and asthma.

Claims for an important role for food sensitivity have also been made for many other conditions, including rheumatoid arthritis,[34-38] hyperactivity in children,[39-46] thrombophlebitis,[47] cutaneous vasculitis,[48,49] nephrotic syndrome,[50] Sjoegren's syndrome,[51] idiopathic thrombocytopenic purpura,[52,53] cardiac arrhythmia,[54] schizophrenia,[55-57] narcolepsy,[58] seizure disorder,[59] "cerebral allergies,"[60] and others.[10,61-62] However, for the most part the studies supporting these claims are not of the same order of quality as the studies reviewed in this paper. Therefore, even tentative conclusions would be premature. What is clear is that acceptance or rejection of these claims will require a commitment to well-designed research and that is beginning to be displayed.

REFERENCES

1. Adams F: *The Genuine Works of Hippocrates*. New York, NY, William Wood & Co., 1886, p. 137.
2. Rowe A, Rowe A Jr: *Food Allergy (Its Manifestations and Control and the Elimination Diets), A Compendium*. Springfield, IL, Charles C. Thomas, 1972.
3. Coca A: *Familial Non-Reagenic Food Allergy*. Springfield, IL, Charles C. Thomas, 1942.
4. Rinkel H, Randolph T, Zeller M: *Food Allergy*. Springfield, IL, Charles C. Thomas, 1951.
5. Randolph T: *An Alternative Approach to Allergies*. New York, NY, Lippincott and Crowell, 1979.
6. Golbert T: Food allergy. *J Med Soc NJ* 77:895-899, 1980.
7. Buckley R, Metcalfe D: Food allergy. *JAMA* 248:2627, 1982.
8. May C: Objective clinical and laboratory studies of immediate hypersensitivity reactions to foods in asthmatic children. *J Allerg Clin Immunol* 58:500-519, 1978.
9. Bock SA, Lee W, Remingio L, et al.: Studies of hypersensitivity reactions in infants and children. *J Allerg Clin Immunol* 62:327-334, 1978.
10. Dickey L: *Clinical Ecology*. Springfield, IL, Charles C. Thomas, 1976.
11. Egger J, Wilson J, Carter C, et al.: Is migraine food allergy? A double-blind controlled trial of oligo-antigen treatment. *Lancet* 11:865-904, 1983.
12. Hoj L: A double-blind controlled trial elemental diet severe perennial asthma. *Allergy* 36:257-262, 1981.
13. Dockhorn R, Smith T: Use of a chemically defin hypoallergenic diet (Vivonex) in the management of patier with suspected food allergy intolerance. *Ann Aller* 47:204-206, 1981.
14. Monro J, Carni C, Brostoff J: Food allergy in migrai Study of dietary exclusion and RAST. *Lancet* 11:1-4, 198
15. Grant E: Food allergies and migraine. *Lanc* 1:966-969, 1979.
16. Vaughn TR, Mansfield L, Haverly R, et al.: The value cutaneous testing for food allergy in the diagnostic evaluati of migraine headache. *Ann Allergy* 50:362, 1983 (abstrac
17. Littlewood J, Glover V, Sandler M: Platel phenolsulphotransferase deficiency in dietary migrai *Lancet* 983-986, 1982.
18. Atherton D, Soothill J, Sewall M, et al.: A double-bli controlled crossover trial of an antigen-avoidance diet atopic eczema. *Lancet* 401-403, 1978.
19. Hill D, Lynch B: Elemental diet in the management severe eczema of childhood. *Clin Allergy* 12:313-314, 198
20. Juto P, Engling S, Winberg J: Treatment of atop dermatitis with a strict elimination diet. *Clin Allergy* 8:49 1978.
21. Sampson H: Role of immediate food hypersensitivity the pathogenesis of atopic dermatitis. *J Allerg Clin Immun* 71:473-480, 1983.
22. Molkou P, Waguet J: Food allergy and atopic dermatit in children: Treatment with oral sodium cromoglycate. *Ar Allergy* 47:173, 1981.
23. Lothe L, et al.: Cow's milk formula as a case of infanti colic: A double-blind study. *Pediatrics* 70:7-10, 1982.
24. Kocoshis S, Grybowski J: Use of cromolyn in combin gastrointestinal allergy. *JAMA* 242: 1169-1173, 1979.
25. Buisseret P: Common manifestations of cow's milk a lergy in children. *Lancet* 304-305, 1978.
26. Wray D: Gluten-sensitive recurrent apthous stomatiti *Dig Dis Sci* 28:737, 1981.
27. Faizallah R, et al.: Adult celiac disease and recurre pericarditis. *Dig Dis Sci* 27:728-730, 1982.
28. Hallert C, Derefeldt T: Psychic disturbances in adu celiac disease. *Scand J Gastroenterol* 17:17-28, 1982.
29. Katz S, et al.: Dermatitis herpetiformis: The skin ar the gut. *Ann Intern Med* 93:857-874, 1980.
30. Doherty M, Barry R: Gluten-induced mucosal chang in subjects without overt small-bowel disease. *Lanc* 517-520, 1981.
31. Alun-Jones V, Shorthouse M, McLaughlin P, et al.: Foc intolerance: A major factor in the pathogeneses of irritabl bowel syndrome. *Lancet* 1115-1117, 1982.
32. Bentley S, Pearson D, Rix K: Food hypersensitivity i irritable-bowel syndrome. *Lancet* 295-297, 1983.
33. Svedlund J, Ottosson J, Sjodin I, et al.: Controlled stuc of psychotherapy in irritable-bowel syndrome. *Lanc* 589-591, 1983.
34. Parke A, Hughes G: Rheumatoid arthritis and food: case study. *Br Med* 282:2027-2029, 1981.
35. Hicklin J, McEwan L, Morgan J: The effect of diet o rheumatoid arthritis. *Clin Allergy* 10:2463-2467, 1980.
36. Kroker G, Stroud R, Marshall R: Comprehensive en vironmental control and its effect on rheumatoid arthriti *The American College of Allergists Third International Foo Allergy Symposium*, October 21, 1980.
37. Little C, Stewart A, Fennessy M: Platelet serotonin re lease in rheumatoid arthritis: A study in food intolerant pa tients. *Lancet* 297-299, 1983.
38. Panush R, Carter R, Katz P, et al.: Diet therapy fo rheumatoid arthritis. *Arthritis Rheum* 26:462-471, 1983.
39. Swanson J, Kinsbourne M: Food dyes impair per formance of hyperactive children on a laboratory learnin test. *Science* 207:1485-1487, 1980.
40. Mathes J: Effects of artificial food colorings in childre with hyperactive symptoms. *Arch Gen Psychiatr* 38:714-718, 1981.
41. Consensus Conference: Diets and childhood hyper activity. *JAMA* 248-290, 1982.
42. Tryphonas H, Trutes R: Food allergy in children wit

eractivity learning disabilities and minimal brain dysction. *Ann Allergy* 42:22-26, 1979.
3. Millman M, Campbell M, Wright K, et al.: Allergy and ning disabilities in children. *Ann Allergy* 36:149-160, 6.
4. Hughes E, Weinstein R, Golt P, et al.: Food sensitivity ttention deficit disorder with hyperactivity (ADD/HA): A cedure for differential diagnosis. *Ann Allergy* :276-280, 1982.
5. Rapp D: Double-blind confirmation and treatment of sensitivity. *Med J Aust* 1:571-572, 1978.
6. O'Shea J, Porter S: Double-blind study of children with erkinetic syndrome treated with multi-allergen extract lingually. *J Learn Dis* 14:189-191, 1981.
7. Rea W: Recurrent environmentally triggered thromhlebitis. *Ann Allergy* 147:338-344, 1981.
8. Rea W: Environmentally triggered small vessel culitis. *Ann Allergy* 38:245, 1977.
9. Theorell H, Blomback M, Kockum C: Demonstration of tivity to airborne and food allergens in cutaneous culitis by variations in fibrinopeptide A and other coagula-, fibrinolysis and complement, parameters. *Thromb emost* 30:598-603, 1976.
0. Sandberg D, Bernstein C, McIntosh R, et al.: Severe roid-responsive nephrosis associated with hypersitivity. *Lancet* 388-391, 1977.
1. Cunningham-Rundles C, Randeis W, Safai B, et al.: ective IgA deficiency and circulating immune complexes taining bovine proteins in a child with chronic graft ver- host disease. *Am J Med* 67:883-890, 1979.
2. Caffrey E, Sladen G, Isaacs P, et al.: Thrombocytopenia sed by cow's milk (letter). *Lancet* 310, 1981.
3. Whitfield M, Barry G: Cow's milk allergy in the syndrome of thrombocytopenia with absent radius. *Arch Dis Child* 51:337, 1976.
54. Rea W: Environmentally triggered cardiac disease. *Ann Allergy* 40:243-251, 1978.
55. Dohan F, Grasberger J: Released schizophrenics: Earlier discharge from the hospital after cereal-free, milk-free diet. *Am J Psychiatry* 130:685-688, 1973.
56. Singh M, Kay S: Wheat gluten as a pathogenic factor in schizophrenia. *Science* 191:401-402, 1976.
57. Potkin S, Weinberger D, Kleinman J: Wheat gluten challenge in schizophrenic patients. *Am J Psychiatry* 38:1208-1211, 1981.
58. Bell I, Guilleminault C, Dement W: Hypersomnia, multiple-system symptomatology and selective IgA deficiency. *Biol Psychiatry* 13:751-757, 1978.
59. Crayton J, Stone T, Stein G: Epilepsy precipitated by food sensitivity: Report of a case with double-blind placebo-controlled assessment. *Clin Electroencephalogr* 12:192-198, 1981.
60. King D: Can allergic exposure provoke psychological symptoms? A double-blind test. *Biol Psychiatry* 16:3-17, 1981.
61. Finn R, Cohen H: Food allergy: Fact or fiction. *Lancet* 426-427, 1978.
62. Gerrard J: *Food Allergy: New Perspectives*. Springfield, IL, Charles C. Thomas, 1980.
63. Ratner P, Davis S, Rodriguez M, et al.: The role of food allergy and dietary manipulation in atopic eczema. *J Allerg Clin Immunol* 73:175, 1984 (abstract).
64. Sampson H, Jolie P: Changes in plasma histamine concentrations following double-blind placebo-controlled food challenges in atopic dermatitis. *J Allerg Clin Immunol* 73:175, 1984 (abstract).

JEMPAC UPDATE*

WILLIAM E. RYAN, M.D., PENNINGTON

The author, as chairman of JEMPAC, presented this speech at the MSNJ Annual Meeting. Examples of political efforts are provided to show the influence of JEMPAC.

A generous thank you from JEMPAC for your political support during the past year. Although we have a long way to go, the past year has been one of unparalleled success in the political arena.

You should know that the PAC movement in this state garnered $81,000 in funds and was contributed to by over 1,300 physicians. Over 600 of you joined JEMPAC and another 700 physicians sent checks to MEDAC. The latter fund was instituted this past year for use in statewide elections.

With that money, we were able to contribute over $66,000 to the campaign of legislators deemed friendly to medicine. It is my sincere belief that more assemblymen and state senators favorably are disposed to the cause of medicine, in general, and to the medical PAC effort, in particular, because of your support.

As you recall, as I addressed you this past year, there were many threats facing medicine. I spoke specifically about a physician fee schedule which was introduced into the language of several bills having to do with automobile insurance reform. Indeed, this time last year, it was a strong probability that right now you would be contending with a state-imposed fee schedule for the treatment of auto accident victims. This has not happened, largely because of the new-found influence and clout which you now enjoy and specifically through the efforts of our Medical Society lobbyist, Joe Katz. Mr. Katz, who spoke before you last year, was very effective in staying the hand of the governor and leg lators who were in favor of an auto insurance bill w a fee control board. This is testimony to what politi influence really can do.

Perhaps our most dramatic moment came in Ju of last year when we were able to thwart the efforts the optometrists in their effort to practice medicine treating diseases of the eye. As you know, the tometrists had a bill introduced which would ha allowed them to treat diseases of the anterior chamb of the eye after receiving a 100-hour instruction cou in pharmacology at Philadelphia College of Optomet We felt there was more to eye disease than a cou in pharmacology. The ophthalmologists were incens and we felt that it generally was an incursion into t practice of medicine that was not in the patient's b interest. We acted to protect the public, physicians, a ophthalmologists to retain control of medical pract in this area. However, it was a fight we almost lost. T bill came to a vote in the assembly where 41 votes w necessary for passage. Through a combined effort multiple parties including the physicians of JEMPA the ophthalmologists, and the Medical Society of N Jersey, particularly again, Joe Katz, the bill fell one v short of approval. It was a victory for us but rest sured that the same bill, albeit, in different langua and perhaps watered down, again has been introduc into the legislature.

In the fall elections, our political action commit

ntributed substantially to the efforts of a number of gislators and candidates who we felt would support edicine. In the state senate, Senator James Bornheimer had been a particular thorn in the side of medine and sat on the very influential L.I.P. Committee. Ve decided to support the candidacy of Peter Garibaldi ho we felt would be more sympathetic to us. It was very close election but Senator Garibaldi today sits Senator Bornheimer's seat.

These are three examples of the political efforts we ave had in the state which have come about through our effort in helping us underwrite the political proess.

That was the state scene. In Washington, the politos had other landmines for us. Specifically, there was e issue of mandated assignment under Medicare hich this year took the form of an attachment to the mnibus Budget Reconciliation Bill (H.R. 5394). The rincipal provisions of the mandatory assignment bill ere as follows: 1) prevailing charge levels for phycian services provided to hospital inpatients would frozen at the June 30, 1984, level for a year; 2) phycians would be required to accept Medicare assignent for all services provided to hospital inpatients ntil six months after the HHS secretary reported to ongress on DRG prospective payments for physician rvices (due July 1, 1985); 3) as a condition of particiation in the Medicare program, each hospital would required to obtain an agreement from each phycian on its medical staff to accept Medicare assignent for all Medicare inpatient hospital services, and ilure of a hospital to comply could force the hospital t of the Medicare program.

A telegram was received from the AMA a day or so efore the vote was to be taken. There was very little me for phone contact with congressional offices but e did our best.

The Auxilary of the Medical Society, headed by Mrs. ale Wayman and a JEMPAC board member, Angie ampo, who were on their legislative visit to Washingn, made a monumental effort to stop this legislation. hey went to individual congressmen's offices to argue at the legislation was not warranted. It was pointed t, that there had been no congressional hearings on e issue. There never have been any data submitted substantiate the need for these positions, indeed hen a physician does not accept assignment, the nancial obligation for payment is outside the risdiction of the Social Security system. It also was gued that physicians were doing their part with the one-year voluntary freeze and that freedom of choice of Medicare beneficiaries would be curtailed if patients found their physicians unable to provide services in hospitals because their staff privileges had been discontinued. Physicians have treated patients who are indigent or of meager means free or at reduced fees in substantial numbers over the years. This seems to be unique to our profession. Have any Medicare beneficiaries been denied care or taken to small claims court? Of course not. This is why we feel very vigorously that we do not deserve this federal action.

Make no mistake about it, you are asked to conform to an onerous federal standard as a requisite to pursue your profession. The government is on the fast track to control you and your practice. We see this class action as entirely unacceptable. We feel that your practice and career are squarely on the line.

We have won a temporary victory. I stress that because the new legislation, particularly the Kennedy-Gephardt bill and perhaps some new legislation introduced by Senator Heinz, contain very similar language to the mandated assignment bill. We will have a tough fight and the American Medical Association, JEMPAC, and the American Political Action Committee are very cognizant of the antimedical antiphysician sentiment in Congress.

I called upon the office of Frank Guarini and was told by his legislative assistant, "You know a lot of the old folks are for this, don't you?" The implication was quite clear that another group of citizens clearly ranked above us in terms of political clout. I think we can thank our lucky stars that this legislation did not get enacted on April 12. What the future holds will depend upon you.

In conclusion, I wanted to point out that we indeed have come a long way in terms of political activity and financial viability. We are an organization "on the roll." We have managed to win some battles this year and to change the political climate to some extent. However, we have a number of major battles facing us in New Jersey and nationally.

The JEMPAC board would like your input on the selection process for candidates we hope to support in the fall federal election. Please let us know which candidates you would like supported and why. It is only in this manner that we can make an informed judgment.

I thank you for your support in the past and look forward to your financial and personal input in the future.

FIFTH ANNUAL MEDICOLEGAL SEMINAR

Wednesday, September 12, 1984
8:30 a.m.- 4:00 p.m.

Medical Society of New Jersey Executive Offices
Two Princess Road
Lawrenceville, NJ 08648
presented by

Medical Society of New Jersey
Department of Professional
Liability Control

Medical Inter-Insurance
Exchange of New Jersey
Department of Risk Management

Morning Session

8:30 Registration and Coffee

9:00 Greetings
Frank Y. Watson, M.D., President, MSNJ and James S. Todd, M.D., Chairman of the Board, MIIENJ

9:20 **Opening Remarks**
James E. George, M.D., J.D., Director, Department of Professional Liability Control

9:45 **"The Snitch Bills; Their Impact on Medical Malpractice"**
Vincent A. Maressa, Executive Director, MSNJ

10:15 **"Reporting of Medical Malpractice To State Board of Medical Examiners"**
Joseph A. Riggs, M.D., Member of State Board of Medical Examiners

10:45 **"The New Case Management and Procedures of Malpractice Litigation"**
Honorable Peter Ciolino, Assignment Judge Superior Court, Passaic County

11:15 **Questions and Answers**

Afternoon Session

12:00 Lunch

12:45 **"Medical Malpractice; The View from the Chair"**
James S. Todd, M.D. Chairman, Board of MIIENJ

1:00 **"The Professional Liability World Today; The State of the Industry"**
Peter Sweetland, President, MIIENJ

1:45 **"The Claim Climate in New Jersey; A History and a Look at the Future"**
Joseph DeRoma, Vice-President, Claims, MIIENJ

2:30 **"An Ounce of Prevention; Causes of Suits and Programs Developed To Avoid Them"**
Adam P. Wilczek, Director, Department of Risk Management, MIIENJ

3:15 **Questions and Answers**

APPROVED FOR 5½ CME CATEGORY I CREDITS

REGISTRATION
PLEASE RESPOND NO LATER THAN AUGUST 31, 1984
NO REFUNDS AFTER SEPTEMBER 10, 1984

MSNJ MEMBER OR MIIENJ INSURED	$10.00
NON MSNJ MEMBER OR NOT INSURED WITH MIIENJ	25.00

DETACH AND MAIL TO MSNJ, TWO PRINCESS ROAD, LAWRENCEVILLE, NJ 08648

Enclosed is my check for_____payable to MSNJ

NAME (PLEASE PRINT)_____

ADDRESS_____

PHONE #_____

A CONFIRMATION WILL BE SENT TO YOU ALONG WITH DIRECTIONS TO MSNJ.

)OCTORS' NOTEBOOK

Trustees' Minutes; UMDNJ Notes; Transfusion Problems; Physicians Seeking Location in New Jersey

'rustees' Minutes Iay 2, 1984

A regular meeting of the Board of rustees was held on May 2, 1984, t Resorts International Hotel and asino, Atlantic City. Detailed inutes are on file with the sec-etary of your county society. A sum-ıary of significant actions follows:

:esolutions of Endorsement . . . ıpproved for presentation at the 984 Annual Meeting, resolutions ndorsing the candidacy of Arthur ernstein, M.D., for election to the MA Council on Scientific Affairs nd Karl T. Franzoni, M.D., for elec-ion to the AMA Council on Medical ervice.

teport of the Executive Director . .

1) MSNJ Paid Membership . . . Noted that 6,905 members paid heir 1984 dues as of April 26, 1984.

2) MSNJ Pension Plan . . . Ap-roved the following two recommen-lations:

That the Horizon Trust Company be ıppointed to conduct trustee and ustodial services for the Medical Society f New Jersey Employees' Pension Plan.

That Jamison, Eaton, and Wood be appointed investment managers of the Medical Society of New Jersey Employees' Pension Plan.

(3) TEFRA—ERISA Compliance . . . Approved the following amended resolution (italics indicate amendment):

That the Committee on Retirement Plan for Physicians review the proposal of Health Care Group and be authorized to permit its offering as an endorsed program of the Medical Society of New Jersey. *Included in the evaluation should be any other plans the Committee feels it is necessary to review.*

(4) MSNJ Employee Pension Plan . . . Approved the following amendment #6 to the Medical Society of New Jersey Pension Plan...

(a) Change definition of compensation to conform to statute.
(b) Temporary restrictions on benefits regarding lump sum payments to the 25 highest paid employees if the Plan has been amended in the last ten years to improve benefits.
(c) Compliance with top heavy rules even though not applicable to MSNJ Plan as such.

(5) Summer Student Research Fellowship Program . . . Authorized appropriation of $1,000 for the Summer Student Research Fellowship Program.

(6) State Board of Medical Examiners . . .
(a) Proposed Rule on Chiropractic . . . Noted that proposed rule, N.J.A.C. 13:35-7.1, concerning chiropractic practice, will be considered at the May 9, 1984, meeting of SBME.
(b) Greco Case . . . Noted a decision is expected 21 to 28 days after the case was argued on April 30.

Medical Society of New Jersey Student Association . . . Received as informative, with commendation, the report of the MSNJ Student Association.

Council on Legislation . . . Approved the recommendation stating the Board approves the positions on bills of medical importance as recommended by the Council.

New Business . . .
Physician Supervision of Limited Licensed Practitioners . . . Approved the suggestion that MSNJ sponsor a program for hospital medical staffs on credentialing limited licensed practitioners in hospitals.

Retiring Members of the Board . . . Expressed appreciation to the following retiring Board members for their dedicated service: Drs. Campo, Crosby, Greifinger, Ramundo, and Slobodien.

Trustees' Minutes May 6, 1984

A reorganization meeting of the Board of Trustees was held on May 6, 1984, at Resorts International Hotel and Casino, Atlantic City. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

Reorganization . . .
(1) New Members . . . Welcomed the following newly elected members of the Board of Trustees: Drs. Bernard Robins, Carl Restivo, Jr., Gerald H. Rozan, Michael M. Heeg, and Louis L. Keeler.
(2) Chairman of Board of Trustees . . . Noted that by reason of the amendment to the Bylaws adopted by the 1984 House of Delegates, Dr. Watson will serve as chairman of the Board of Trustees.
(3) Meeting Schedule . . . Voted to continue meeting on the third Sunday of each month at MSNJ headquarters in Lawrenceville.

Standing Committee on Finance and Budget . . . Appointed Drs. Carnes, Costabile, and Schauer to three-year terms on the Standing Committee on Finance and Budget.

New Business . . .
(1) Annual Meeting Attendance . . . Noted that an attempt should be made to discover the reason for declining attendance at the Annual Meeting.
(2) NJ State Medical Underwriters, Inc. . . .
(a) Report on Activities . . . Received a report of activities by James S. Todd, M.D., as well as the Annual Report of MIIENJ and a special report of NJ State Medical Underwriters, Inc.

(b) Board of Directors Appointments . . . Approved the reappointment of Dr. Paul J. Kreutz to a three-year term and noted Dr. Watson designated Dr. Slobodien to serve as his appointee.

(3) Referrals from 1984 House of Delegates . . .

(a) Resolution #11—Quality of Care Audit of Services . . . Directed that a communication be sent, informing the Commissioner of Health that MSNJ still is interested in having a proper study conducted on the quality of care audit of services under the DRG program and to see if adequate funds are available to complete the study.

(b) Resolution #28E—JCAH Medical Staff Standards . . . Referred Resolution #28E (1984 JCAH medical staff standards) to Dr. A. Ralph Kristeller, chairman of the NJ Chapter of the Hospital Medical Staff Section, for presentation to the AMA Section.

(c) Resolution #3—Premium Discount, Professional Liability Insurance . . . Referred the following to the Risk Prevention Committee of MIIENJ with a request for a report on premium discounts:

Resolved, that the Medical Society of New Jersey, in conjunction with the Medical Inter-Insurance Exchange of New Jersey and other commercial carriers, be urged to prepare and present appropriate seminars on basic medical-legal matters; and be it further

Resolved, that consideration be given by the Medical Inter-Insurance Exchange of New Jersey and other commercial carriers to provide a discount of premium costs for members of the Medical Society of New Jersey who successfully complete the seminar, provided it can be demonstrated that such educational programs decrease liability claims against the insured.

(d) Resolution #9—Prevention of Windfall Profits . . . Referred the following to the Council on Medical Services and the Committee on Medical Defense and Insurance for consideration:

Resolved, that the Medical Society of New Jersey seek the passage of legislation that requires carriers that pay a lower fee, when a nonparticipating physician renders a service, to pay a premium rebate or dividend to the insured patient.

(e) Resolution #16—Opposition to Mandatory Assignment under Medicare . . . Referred the following to the AMA Delegation for introduction at the 1984 AMA Annual Meeting:

Resolved, that the Medical Society of New Jersey request that the American Medical Association continue to oppose vigorously any attempt by Congress to direct in any fashion mandatory assignment under Medicare.

(f) Resolution #24—Mandatory Assignment . . . Referred the following to the AMA Delegation for introduction at the 1984 AMA Annual Meeting:

Resolved, that the Medical Society of New Jersey urge the American Medical Association to research the constitutionality of mandatory assignment being proposed by Congress or any other proposal to force physicians to accept prestipulated fees.

(g) Resolution #15—Patient Education Program . . . Referred the following to the Council on Public Relations for study and a report, and to the Committee on Finance and Budget for study:

Resolved, that the Medical Society of New Jersey conduct a "patient education" program, designed to inform the general public regarding the underpublicized factors involved in health care costs and the threat posed to the quality and availability of said care; and be it further

Resolved, that an assessment of $100 be levied upon each member in order to fund this proposal.

Also, requested the Council on Public Relations to obtain at least two proposals from public relations firms to study the most effective way to reach the public and the cost thereof. In addition, noted that a re-evaluation of the budget should be made to determine whether an increased allowance is needed for public relations.

(h) Resolution #26—Advertising on Behalf of HMOs by Department of Health and Human Services (HHS) . . . Directed that a letter be sent to Department of HHS regarding HMO advertising and that the following be referred to the AMA Delegation:

Resolved, that the Medical Society of New Jersey protest to the United States Department of Health and Human Services that they cease and desist from using such tactics to promote the growth of health maintenance organizations at the expense of the private practitio through the use of taxpayer funds prepare and mail this prejudic advertising; and be it further

Resolved, that the Medical Society New Jersey present a resolution at next AMA House of Delegates, r ommending concurrent action by AMA.

(i) Resolution #29E—NJ St Board of Medical Examiners P nouncement of Death Regulati . . . Referred the following to the E ecutive Committee for discussi with appropriate members of t SBME:

Resolved, that the Medical Society New Jersey take immediate steps to quest changes in the regulation to move the requirement that the patien attending physician make the p nouncement of death. This service can provided more efficiently by the em gency room doctor at the nearest hos tal or the county medical examiner; a be it further

Resolved, that the Medical Society New Jersey take steps to change the reg lation to state that the county medi examiner may call the attending ph sician and ask him to make the p nouncement but that it is not a requi ment that he do so.

(4) Resolution #19—Mammogr phy . . . Voted to pospone action c the following until the 1985 Annu Meeting:

Resolved, that the Medical Society New Jersey adopt and endorse the guid lines advocated by the American Colle of Radiology and others as follows: Women between the ages of 35 and 4 years of age should have a baseline mar mogram; b) Between ages 40 and 50, fr quency of mammography should b every two years. Clinical or risk facto evaluated by the patient's physician ma alter this frequency; and c) After age 5 yearly mammography is recommende and be it further

Resolved, that mammograms followin from these recommendations should b made with equipment designed for th procedure.

UMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

Our UMDNJ faculty members re cently have been granted tw patents that promise to improv health care for the people of New Jer sey and the world.

David M. Goldenberg, Sc.D., presi dent of UMDNJ's Center for Mo lecular Medicine and Immunol

(CMMI), has been granted a ent for a detailed method of de- ting and localizing tumors. The ent is assigned to Immuno- dics, Inc., the private corporation ich Dr. Goldenberg heads.

A research team headed by Ralph Greco, M.D., professor of surgery d chief of general surgery at IDNJ-Rutgers Medical School, s been granted a patent for the ocess of bonding antibiotics to ificial implants. Also, the Food d Drug Administration has ap- oved the process for additional rgical procedures.

f the antibiotic bonding process ented by the UMDNJ team works well with humans as it has with oratory animals, its application ld save lives now lost because of ections that often develop after plant surgery.

The FDA, which in 1983 granted mission for the bonding process be used in vascular implants, has ended experimental permission hyperalimentation catheters, ap- oved in 1984. Approval for perito- al dialysis is pending.

n hyperalimentation, a plastic heter is placed in a large vein rough which a patient is fed in- venously, a procedure widely used malnourished patients before and er major surgery. The UMDNJ re- archers anticipate that an anti- otic bonded catheter will be more sistant to infections and thus de- ease the incidence of complica- ns and increase utilization of the ocedure.

Peritoneal dialysis involves im- nting a tube in the abdominal vity. In cases of kidney failure, it rmits continuous ambulatory ansing of body wastes and re- ces the patient's dependence on e machine. Infection of the heter, the most common com- cation, requires the catheter to be moved and dialysis to cease. If the tibiotic bonded catheters succeed preventing infection, they will ve a major impact on the use of is technique.

Dr. Goldenberg, who is based on e Newark campus, has also re- ved three previous patents, and s two patent applications pend- g. All relate to cancer detection d therapy. Cancer radioimmuno- tection, which combines advances immunology and nuclear medi- ne imaging, detects cancers in the human body by injecting radioactive antibodies made against cancer-associated substances. These same antibodies also can carry other radioisotopes, drugs, and other agents to combat cancer cells, thus offering hope of more effective therapy as well as diagnosis.

CMMI, which was established on the Newark campus in September 1983, held its formal opening and dedication on June 13. The center has initial three-year funding of more than $3 million, most of it from the National Cancer Institute.

The CMMI research and therapy efforts and goals are allied closely to the new Cancer Research and Treatment Center (CRTC), also on the Newark campus. The CMMI staff interacts with the faculty members of the New Jersey Medical School on the staff of the CRTC.

A "definitive study" on the feasibility of relocating United Hospitals Medical Center to the Newark campus has been commissioned by the boards of both institutions.

APM Inc., New York City-based planning consultants, will assess the benefits and risks of the proposed "colocation" project, as well as the financial and legal implications, before offering a comprehensive package of recommendations. The task before the consultants is to elaborate on and refine a preliminary feasibility study, performed in 1982.

A final report is anticipated this fall, in time for a formal colocation proposal to be submitted for state review and approval as part of an Essex County-wide package of proposed hospital renovation and expansion projects.

In addition to the project's potential for cost efficiencies, colocation holds other immeasurably exciting prospects. Joined together, the two medical facilities would comprise a new health care complex rivaling any of the nation's academic medical centers and, more importantly, provide the impetus for a major revitalization of Newark.

In a unique research project at the Piscataway campus, recovered compulsive gamblers and nongamblers are being tested in separate situations to determine whether there are biological factors which predispose some people to become compulsive gamblers, or whether the problem is strictly psychosocial.

The project, funded by a renewable $75,000 grant from the New Jersey Lottery Commission, has been set up by Peter L. Carlton, Ph.D., professor of psychiatry at UMDNJ-Rutgers Medical School, in collaboration with Drs. Leonide Goldstein, Paul Manowitz, and Marshall Swartzburg, also of the Department of Psychiatry.

The first step in the three-part program of research involves testing complusive gamblers doing "organizational" tasks while their brainwaves are recorded on an encephalogram, or EEG.

The second and third parts of the study involve testing nongamblers to determine the characteristics of their brain organization and to study biochemical changes when they are gambling with real money.

Dr. Carlton believes that some means of biological treatment can be found to help compulsive gamblers "kick" their habit, and that studies of the compulsive gambler may open up avenues for understanding of other deviant behavior.

Federal researchers under leadership of NIH investigator Dr. Robert Gallo, who said they had uncovered the probable cause of acquired immunodeficiency syndrome (AIDS), credited the UMDNJ-New Jersey Medical School with helping to provide the clinical case study and laboratory specimens which got them on track to that discovery. James M. Oleske, M.D., associate professor of immunology, said that a key part of the medical school's contribution consisted of tissue and blood samples from children who are being treated for AIDS which were sent to researchers at the National Institutes of Health. Dr. Oleske was the first in the country to present findings that the disease can be transmitted to children.

Practical Solutions to Common Transfusion Problems

H.L. TAYLOR, M.D.*

Brief guidelines for indications of blood components are available from

*Dr. Taylor is Medical Director of the North Jersey Blood Center, East Orange.

health care transfusion services. These are provided as package inserts by the blood component provider *(Circular of Information for the Use of Human Blood and Blood Components)* and are required to be distributed by federal edict. Although between 80 and 90 percent of all blood products transfused either are components or commercial derivatives, guidelines addressing the more common clinical problems associated with transfusion are sparse and are scattered in the literature. This guide will summarize the more common clinical problems associated with component transfusion and offer practical measures to alleviate these difficulties.

RED BLOOD CELL COMPONENTS

One of the most common complaints with transfusion therapy is the slow rate of flow most often associated with packed red blood cells. Whole blood collected in CPD-A1 is converted to red cell components. The resulting hematocrit approaches 80 percent. This significantly increases the viscosity of the red cells and contributes to slow flow rates when red cell components are transfused. A number of other medical devices that are used when these components are transfused also may contribute to the problem and impede flow.

1. Red blood cell components, unlike whole blood, appear homogeneous even though 20 percent or more of the content of these units are fluid and have a higher specific gravity than plasma or normal saline. The cellular elements in these units are denser and will be in high concentration at the most dependent part of the unit. When red cells are being transfused, the most dependent part of the transfusion bag is the point at which the outlet ports are located. Unless the unit is mixed thoroughly before and during transfusion, the red cells will collect around the outlet port, resulting in increased viscosity around this a and this will decrease the flow r

2. All blood components sho be transfused through filters to p vent aggregates and particulate m ter from being infused into the tient. Standard blood filters hav pore size of approximately 170 crons. In microaggregate filters, pore size may vary from 10 to microns. Both cause resistance flow. Microaggregate filters ca more resistance than stand filters and should be used only wh medically indicated. The pores both standard and microaggreg filters will become clogged after s eral units have been transfused, a this will impede further the f rate. These filters should be chan frequently, particularly in emerg circumstances and when a pati requires massive transfusion.

3. In massive transfusion, change transfusion, and some ot clinical circumstances, in-line blo warming devices frequently used. These increase the surf area over which red cell compone flow and, therefore, add resistar Their use should be avoided wh not indicated.

4. Good vascular access with large gauge needle is essential rapid transfusion of red cell com nents. If either is neglected, ceptable transfusion rates cannot achieved.

5. The use of "Y" sets when tra fusing red cells has numerous vantages. It allows in-line tra fusion devices to be primed purged of air or compatible infus products. Vascular access can maintained between the time t components are being administer Also, the appropriate intraven solution can be added to and mi with a unit of red cells in order decrease viscosity and improve fl The only pharmacological co patible intravenous solution propriate for transfusion or mix with any blood component is nor saline (0.9 percent NaCl in H U.S.P.). Ringer's solutions will ca clot formation. No drugs should e be administered with a blood co ponent through a transfusion s

6. In some circumstances pr sure cuff devices are necessary rapid transfusion. Hemolysis of cells may occur if extreme press is used to force red cells which h been mixed inadequately throu

The Journal of The Medical Society of New Jersey

presents

"300 YEARS OF MEDICINE IN NEW JERSEY"

This special issue will be available in September 1984

lters of small pore size or which ontain particulate matter. This azard also can occur when red cells re transfused through partially obtructed intravenous lines or rough small gauge needles.

LATELET CONCENTRATES

Platelet transfusions usually are ot effective in patients who have apid platelet destruction. These onditions include idiopathic rombocytopenic purpura (ITP) nd untreated disseminated intravascular coagulopathy (DIC). Patients with thrombocytopenia due to epsis or hypersplenism also may il to benefit from platelet transsions, as may patients with functional platelet disorders such as hose caused by uremia or drugs. In hese patients the underlying cause f the platelet disorder should be reated if beneficial effects of platelet ransfusion are to be realized.

Platelet concentrates must be administered through a filter. lthough some reports indicate that latelets may be transfused through icroaggregate filters, it is recmmended that pooled platelet conentrates be infused through special dministration sets within six ours.

In massively bleeding patients, latelet transfusion is most effective n achieving hemostasis if it takes lace after the source of bleeding is rst controlled by surgical or mechnical means.

EUKOCYTE CONCENTRATES

Leukocytes collected by pheresis f single donors contain 1.0 x 10^{10} ranulocytes, variable amounts of mphocytes, platelets, and red blood ells. The presence of large quanities of platelets frequently is eneficial as many neutropenic paients also are thrombocytopenic. his component should be transused as soon as possible and only standard blood filter should be sed.

Indications for transfusion vary rom institution to institution but sually include the following: yeloid aplasia, neutropenia (<500 MN/μ1), and fever unresponsive to n appropriate antibiotic trial for 24 o 48 hours. Because of the short alf-life of granulocytes and the difficulties inherent in preparation, se of this component should be anticipated as much as possible and the transfusion service should be notified in advance when this transfusion may be required.

Chills, fever, and allergic reactions frequently occur when leukocyte components are transfused. Use of antihistamines, steroids, and nonaspirin antipyretics in premedicating the recipient may prevent or ameliorate these reactions. Severe febrile and pulmonary reactions to leukocyte concentrate transfusion may preclude their use in some patients.

SINGLE-DONOR PLASMA (FRESH FROZEN)

Fresh frozen plasma (FFP) is one of the most abused of all blood components. It should not be used to provide blood volume expansion. Osmotically balanced blood derivatives, crystalloid, or colloid, are more appropriate in these circumstances. Similarly, FFP should not be used as a hyperalimentation substitute in the nutritionally deficient patient. Fresh frozen plasma is indicated for bleeding patients with multiple coagulation factor deficiencies secondary to liver disease, massive blood replacement, and DIC. Since therapeutic levels of procoagulants are approximately 30 percent of normal values, there is no rationale to replace plasma loss on a unit-for-unit basis.

FFP also is used for patients with hereditary factor deficiencies for which there is no coagulation concentrate available, i.e. factor V or XI deficiencies. It also may be useful for patients with mild hereditary and acquired factor deficiencies. The patient's ability to tolerate the infusion volume of plasma without developing fluid overload must be considered.

FFP should be administered through a filter within 6 hours of thawing. Some published guidelines allow transfusion of FFP within 24 hours of thawing, but both state and federal regulations require transfusion within 6 hours.

CRYOPRECIPITATE

Cryoprecipitate consists of the cold insoluble portion of fresh frozen plasma and contains concentrates of factor VIII, Von Willebrand's factor, factor XIII, and fibronectin. Cryoprecipitate can be used to treat some patients with hemophilia A, Von Willebrand's disease, hypofibrinogenemia and factor XIII deficiencies.

A recently recognized protein in cryoprecipitate is opsonic glycoprotein (fibronectin) which may be beneficial in reticuloendothelial clearance of foreign particles and promotes wound healing.

Some blood component providers prepare these components "dry" with no supernate in a unit to resuspend the cryoglobulins in solution for effective transfusion. When this method of preparation is used, a small quantity of normal saline must be added to the unit to dissolve this component. When this component is prepared by a "wet" method, i.e. leaving 15 to 20 cc of supernatant plasma in the unit to facilitate resuspension, these difficulties are infrequent.

Whether this component is administered as multiple single units or is pooled into one container, a standard blood filter or a filter needle must be used during transfusion. In either case the component bags should be rinsed with a small volume of saline to assure optimal recovery of the cryoprecipitate constituents. After thawing, this component must be transfused within six hours and appropriate post-transfusion clinical assays (factor VIII, fribrinogen, PT, and PTT) should be monitored to assess the effectiveness of treatment.

AVAILABILITY OF BLOOD COMPONENTS

Blood and its components frequently are in short supply. Since only about 3 percent of the eligible population voluntarily donates blood, it becomes the responsibility of the blood centers to produce components from each donation so that it may serve the needs of as many patients as possible. It also is the responsibility of each transfusion service to utilize these blood components as effectively as possible.

The concept of the "universal red cell donor" (Group O, Rh^0(D) negative) and the "universal plasma donor" (Group AB, Rh^0(D) negative) had its origins in the combat experience of World War II. This concept remains a legitimate protocol in urgent, life-threatening clinical circumstances, but it has become distorted to include nonurgent and

routine transfusion practices. This unfortunate policy severely compromises blood utilization and availability. The group O patient cannot receive any other type of red cell component. The group AB patient cannot receive any other type of plasma component. If group O red cell components or group AB plasma components are used indiscriminately as "universal types" in routine circumstances, patients of these types requiring component therapy may not have them available for transfusion. The "universal red cell and plasma donor" types are not "universal red cell and plasma recipients." Type specific red cells and plasma components should be transfused whenever possible.

Availability of blood components can be improved markedly by instituting Maximal Surgical Blood Order Schedules (MSBOS) and/or Type and Screen (T&S) Protocols that are appropriate in individual health care facilities. Guidelines for instituting these procedures can be found in the references.

An active transfusion committee, which includes peer review from many medical disciplines, also can curtail wasteful transfusion practices.

SELECTED REFERENCES

1. American Association of Blood Banks: *Circular of Information for the Use of Human Blood and Blood Components.* American Red Cross, Washington, 1981.

2. D'Aguillo A, et al.: Guidelines for the administration of blood and blood products. *J Med Soc NJ* 80:437-443, 1983.

3. Freidman BA: The maximum surgical blood order schedule, in Polesky HG, Walker RH (eds), *Safety in Transfusion Practices.* CAP, Aspen Conference, 1980.

4. Greenwalt TJ, et al.: *General Principles of Blood Transfusion.* Chicago, IL, AMA, 1980.

5. Henry JB: Type and screen, in Polesky HF, Walker RH (eds), *Safety in Transfusion Practices.* CAP, Aspen Conference, 1980.

6. Mollison PL: *Blood Transfusion in Clinical Medicine. Seventh Edition.* Oxford, Blackwell Scientific Publications, 1983.

7. Pittiglio DH: *Modern Blood Banking and Transfusion Practices.* Philadelphia, PA, F.A. Davis, 1983.

8. Snyder EL: *Blood Transfusion Therapy: A Physician's Handbook.* Arlington, VA, American Association of Blood Banks, 1983.

9. Wallas CH, Muller VH: *The Hospital Transfusion Committee.* Arlington, VA, American Association of Blood Banks, 1982.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ALCOHOLISM—George W. Miller, Jr., M.D., 77 Grove St., Apt. 8, Montclair, NJ 07042. UMDNJ 1980. Available.

ALLERGY/IMMUNOLOGY—Leonard Bielory, M.D., 688 Concerto La., Silver Spring, MD 20901. UMDNJ 1980. Board eligible. Solo preferred, but flexible. Available March 1985.

T.M. Bokhari, M.D., 48 Anderson Pkwy., Cedar Grove, NJ 07009. FJMC. Also infectious diseases (pediatric). Board certified (PED). Group, partnership, solo. Available.

ANESTHESIOLOGY—Cau Pham, M.D., 856 Nelson, Apt. 206, Chicago, IL 60657. Saigon (South Vietnam) 1974. Group or partnership. Available.

R.S. Saraiya, M.D., 88-25A 153rd St., Apt. 4-F, Jamaica, NY 11432. Baroda (India) 1978. Group or partnership. Available August 1984.

FAMILY MEDICINE—Laurence Levenberg, M.D., 63 Harrowgate Dr., Cherry Hill, NJ 08003. SUNY-Upstate 1966. Group, partnership, solo. Available.

GASTROENTEROLOGY—Harry D. Burack, M.D., 5548 Waterman Pl., St. Louis, MO 63112. Albany 1978. Also internal medicine. Board certified. Partnership, group, solo. Available.

Prakash V. Huded, M.D., 80-15 41 Ave., Apt. 606, Elmhurst, NY 11373. Karnatak (India) 1970. Board certified. Solo, group, partnership. Available.

H.L. Kirschenbaum, M.D., 780 Woolley Ave., Staten Island, NY 10314. New York Medical College 1977. Board eligible. Also, internal medicine. Partnership, group, full-time hospital. Available.

Neil Tarkin, M.D., 6700 192nd St., Fresh Meadows, NY 11365. New York Medical 1978. Also, internal medicine. Board certified (IM). Any type practice. Available.

Mark F. Tsai, M.D., 1715 Stanford Dr., Columbia, MO 65201. National Taiwan University 1977. Also, internal medicine. Board certified. Available.

INTERNAL MEDICINE—Harry D. Burack, M.D., 5548 Waterman Pl., St. Louis, MO 63112. Albany 1978. Also gastroenterology. Board certified. Partnership, group, solo. Available.

Z.U.A. Farooqui, M.D., Plaza Professional Bldg., Bayshore Rd. an Greenwood Ave., Box 238, Villas, N 08251. Aurangabad Medical Colleg (India) 1972. Board eligible. Group o partnership. Available.

Aditi Gupta, M.D., 27 Sturbridge D West, Piscataway, NJ 08854. Lad Hardinge (India) 1980. Board eligibl Clinic/hospital or group. Available.

H.L. Kirschenbaum, M.D., 780 Woolle Ave., Staten Island, NY 10314. Ne York Medical College 1977. Boar eligible. Also, gastroenterology. Par nership, group, full-time hospita Available.

Quang T. Nguyen, M.D., 15 V Englewood Ave., Bergenfield, NJ 0762 Saigon (South Vietnam) 196 Subspecialty, nephrology. Boar eligible. Any type practice. Available.

Claudia Anne Pollet, M.D., 611 Parkway Dr., Baltimore, MD 2121 Mount Sinai 1981. Board eligibl Salaried position in emergency roon clinic, or urgent care center. Availabl

Paul V. Renda, M.D., 3206 Myra St Apt. D, Durham, NC 27707. Mour Sinai 1981. Board eligible. Solo, grou clinic (preferably southern NJ). Avai able.

Richard B. Schwarz, M.D., 8300 D Longpre Ave., Apt. 204, Los Angeles, C 90069. NYU 1979. Subspecialt nephrology. Board certified. Grou HMO, hospital. Available.

Gopal Shah, M.D., 100 Caton Ave., Ap 2-G, Brooklyn, NY 11218. M.R. Medic College (India) 1976. Board eligibl Group. Available.

Neil Tarkin, M.D., 6700 192nd St Fresh Meadows, NY 11365. New Yor Medical 1978. Also, internal medicin Board certified (IM). Any type practic Available.

Steven Wolinsky, M.D., 1404 E. 15 St Brooklyn, NY 11230. Case Western R serve 1980. Group or partnershi Available.

NEPHROLOGY—Quang T. Nguyen, M.D 15 W. Englewood Ave., Bergenfield, N 07621. Saigon (South Vietnam) 196 Also, internal medicine. Board eligibl Any type practice. Available.

Richard B. Schwarz, M.D., 8300 D Longpre Ave., Apt. 204, Los Angeles, C 90069. NYU 1979. Also, internal med cine. Board certified (IM). Group, HM hospital. Available.

OBSTETRICS/GYNECOLOGY—Balwan K. Chhatwal, M.D., 6416 Fairfield Ave Berwyn, IL 60402. Delhi (India) 197 Group, partnership, solo. Available.

Sheela Choubey, M.D., 1 Zirkel Ave Piscataway, NJ 08854. Poona (India 1977. Board eligible. Group or partne ship. Available.

Edwin R. Guzman, M.D., 1200 E. 98t St., Brooklyn, NY 11236. New Yor Medical 1980. Board eligible. Group o partnership. Available Septembe 1984.

Atul S. Sheth, M.D., 2951 S. King Dr Chicago, IL 60616. T.N. Medical Colleg

ndia) 1972. Specializing in infertility, eproductive endocrinology. Board ligible. Partnership, single or multiple roup practice, academia. Available.

rnest A. Topran, M.D., 3523 Dewerry-Southern Oaks, Shreveport, LA 1118. Louisiana State 1980. Group or artnership. Available.

DIATRICS—Dorothea H. Gross, M.D., 64 Boonton Turnpike, Lincoln Park, IJ 07035. Geneva (Switzerland) 1950. linic, group, emergency room, hospial, pharmaceutical research (salaried). vailable.

usumam Sidharthan, M.D., 222 orkshire Ct., Old Bridge, NJ 08857. alicut Medical College (India) 1976. oard eligible. Available.

DIOLOGY/NUCLEAR MEDICINE—onrad P. Erlich, M.D., 1243 Beacon t., Apt. 3B, Brookline, MA 02146. Bosn 1976. Board certified. Group or artnership. Available.

lindy M. Horrow, M.D., 131 Pond rook Rd., Chestnut Hill, MA 02167. ledical College of Pennsylvania 1980. oard eligible. Group, HMO, academia. vailable.

ubhash S. Pujara, M.D., Box 391B, Rt. , Andalusia, AL 36420. B.J. Medical ollege (India) 1969. Board certified radiology); board eligible (nuclear nedicine). Group, partnership, solo. vailable.

RGERY, GENERAL—Sara A. Case, I.D., 284 Quinby Rd., Rochester, NY 4623. Virginia 1975. Board eligible. roup—general surgery in moderateized city. Available August 1984.

uben J. Delgado, M.D., 7514 Oriental r., San Antonio, TX 78244. Puerto ico 1976. Also, vascular surgery. oard certified. Single or multipecialty group or solo. Available ugust 1984.

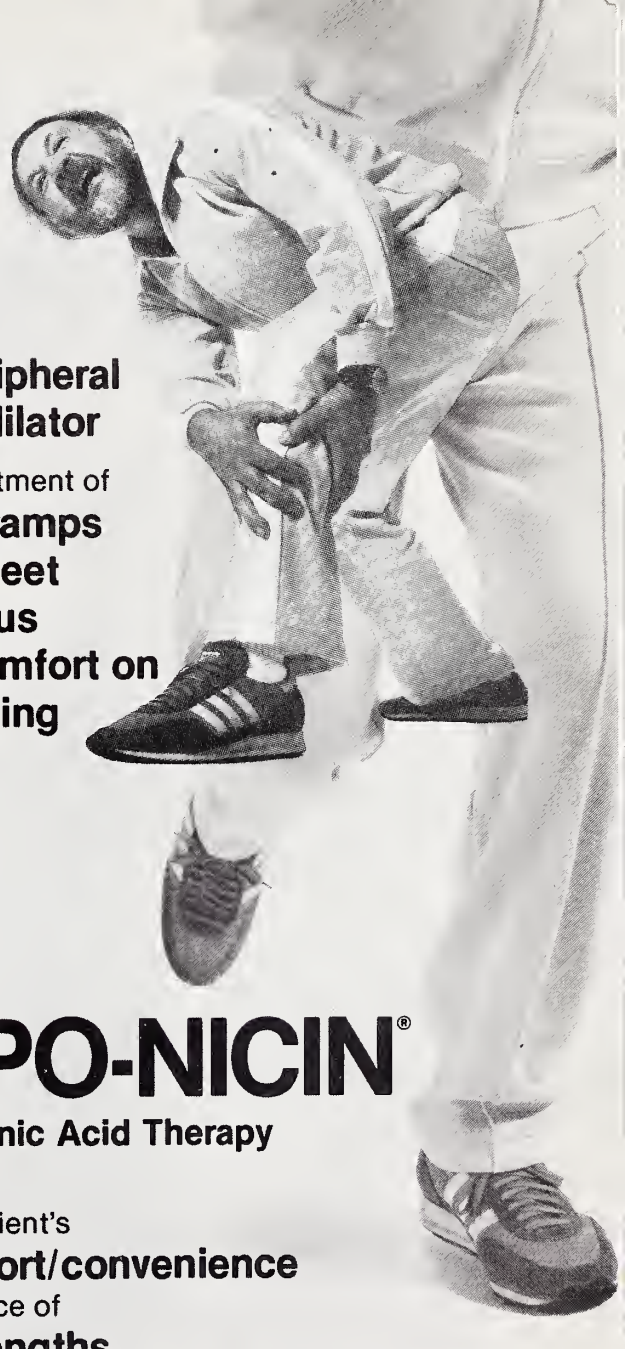
eonardo A. Garduno, M.D., 2170 S. oebbert Rd., Apt. I-109, Arlington eights, IL 60005. University of the ast (Philippines) 1968. Any type prac ice. Available.

ames M. Stern, M.D., 600 Vista Court, Vaynesboro, PA 17268. Jefferson 958. Board certified. Solo, with freelom to practice in broad spectrum of urgery, including vascular and fracures. Available.

RGERY, ORTHOPEDIC—S.N. araiya, M.D., 88-125A 153rd St., Apt. -F, Jamaica, NY 11432. Baroda (India) 974. Solo. Available August 1984.

RGERY, VASCULAR—Ruben J. elgado, M.D., 7514 Oriental Tr., San ntonio, TX 78244. Puerto Rico 1976. lso, general surgery. Board certified GS). Single or multispecialty group or olo. Available August 1984.

OLOGY—Kiritkumar M. Pandya, I.D., 950 49th St., Apt. 9-A, Brooklyn, Y 11219. Baroda (India) 1970. Board ligible. Group, partnership, solo. Avail ble.



A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release
LIPO-NICIN®/300 mg.

Each time-release capsule contains:
Nicotinic Acid .....300 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release
LIPO-NICIN®/250 mg.

Each yellow tablet contains:
Nicotinic Acid .....250 mg.
Niacinamide .....75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide .....75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

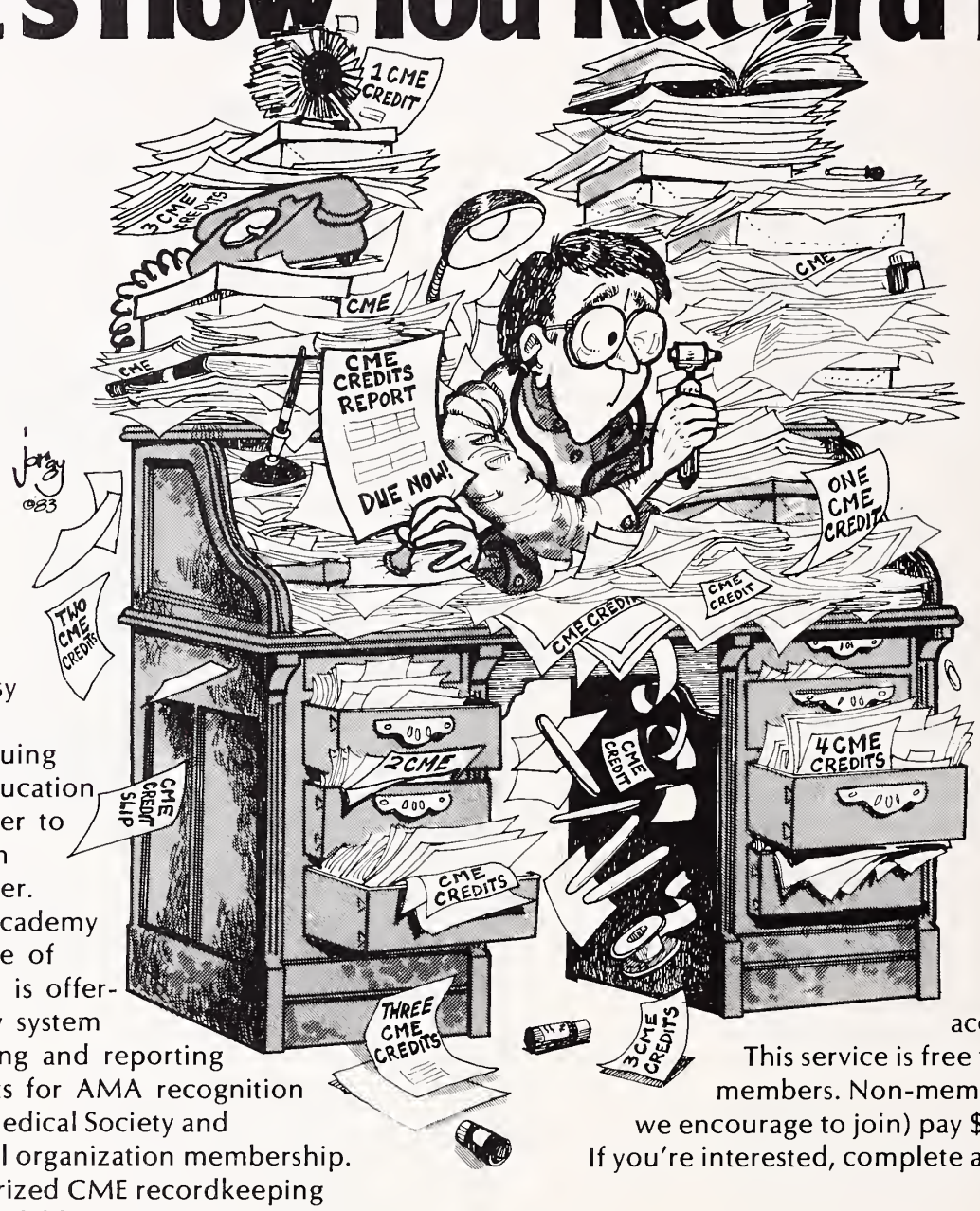
Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

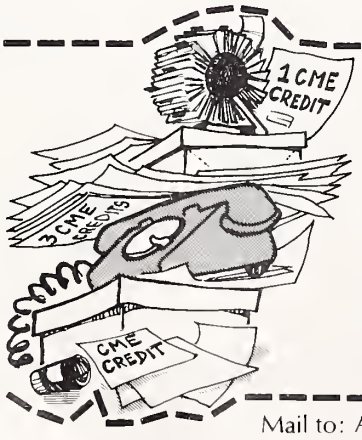
It's Not What You Know, It's How You Record It.



Most busy physicians find continuing medical education credits easier to collect than to remember.

So the Academy of Medicine of New Jersey is offering an easy system for recording and reporting CME credits for AMA recognition as well as Medical Society and professional organization membership. A computerized CME recordkeeping system is available to every New Jersey physician. All you do is send us a reporting card (which your office staff can complete). We'll keep your records and keep you informed semi-annually of your accumulation. This service is free to Academy members. Non-members (whom we encourage to join) pay $30 per year. If you're interested, complete and mail this coupon.

Note: The Medical Society of New Jersey accepts these CME Reports as documentation to meet CME membership requirements.



Please register me for AMNJ's computerized CME record-keeping service.

Name _____

Address _____

City _____ State _____ Zip _____

Telephone Number _____

Your New Jersey Medical License No. (five numerical digits only)_ _ _ _ _

Academy member: Yes ☐

No ☐ Please enclose check

Interested in Academy membership: Yes ☐ No ☐

Mail to: Academy of Medicine of New Jersey, 2 Princess Road, Lawrenceville, NJ 08648

CME CALENDAR

The following is a list of continuing medical education courses for the next two months. Contact the sponsoring organization for further information.

This list is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the UMDNJ. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

CARDIOLOGY

Sept.

21 **Advanced Cardiac Life Support-Provider**
22 7:00 P.M. —Helene Fuld School of Nursing, Camden
23 *(West Jersey Health System and AMNJ)*

MEDICINE

Sept.

6 **Evaluation and Assessment of the Allergic Child**
9 A.M.—Freehold Area Hospital
(AMNJ)

20 **Ontogeny of the Immune System**
27 **Immune Responses and Regulation**
4-6 P.M.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

NEUROLOGY/PSYCHIATRY

Aug.

2 **Neurological Diagnosis in Psychiatric Syndromes**
9 **Attention Deficit Disorder**
16 **The Animal Connection**
30 **Premenstrual Syndrome—Psychiatric and Medical**
12 noon-1 P.M. —Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

Sept.

5 **Computer and Clinical Psychiatry**
9:15 A.M.-4:45 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

6 **Late Onset Schizophrenia**
13 **Depression: Current Management and Future Directions**
20 **Social Management of Breast Cancer and Surgery**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

12 **Cognitive Rehabilitation in a Geriatric Medical Center**
8:30 A.M.-4 P.M.—Bldg. 93, VA Medical Center, Lyons
(VA Medical Center and AMNJ)

12 **The New Antidepressants**
1-2:30 P.M.—Bldg. 93, VA Medical Center, Lyons
(VA Medical Center and AMNJ)

20 **Symposium—New Frontiers in**
21 **Cognitive Rehabilitation**
22 All day—Hyatt Regency, Princeton
(Robert Wood Johnson, Jr. Lifestyle Institute and Natl. Head Injury Foundation)

OBSTETRICS/GYNECOLOGY

Aug.

15 **Drugs, Alcohol, and the Pregnant Woman**
8:30 A.M. -3:15 P.M. —Monmouth Medical Center, Long Branch
(Div. of Alcoholism, NJ State Dept. of Health, and AMNJ)

RADIOLOGY

Sept.

18 **Nuclear Magnetic Resonance**
12 noon—St. Mary's Hospital, Orange
(AMNJ)

SURGICAL SPECIALTIES

Sept.

20 **Thoraco-Abdominal Aneurysm**
5:15-6:15 P.M.—Shore Memorial Hospital, Somers Point
(Shore Memorial Hospital and AMNJ)

MISCELLANEOUS

Sept.

5 **Computers in Medicine/Psychiatry**
9:15 A.M.-4:45 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

19 **CME Workshop**
9 A.M.-4 P.M.—MSNJ Executive Offices, Lawrenceville
(MSNJ and AMNJ)

CME INFORMATION

*Essentials and Guidelines for Accreditation of Sponsors of Continuing Medical Education**

Guidelines to the Essentials have been developed in order to explain in greater detail the meaning and application of the *Essentials* and to provide information to sponsors on how they can comply with the *Essentials*. These guidelines are not intended to limit the manner in which sponsors may meet the requirements for accreditation. Examples cited are intended only for clarification, not as indications of preferences or priorities. The *Guidelines* follow the organizational structure of the *Essentials*. The text of the introduction and each Essential with its explanation and rationale is given first, followed by the corresponding *Guidelines*.

INTRODUCTION

The Accreditation Council for Continuing Medical Education (ACCME) conducts a voluntary accreditation program for institutions and organizations providing continuing medical education (CME). By evaluating and granting recognition to an institution or organization whose CME program substantially complies with the standards or *Essentials*, the ACCME seeks to improve the quality of CME and to assist physicians in identifying CME programs which meet these standards.

The ACCME recognizes that the professional responsibility of physicians requires continuous learning throughout their careers, appropriate to the individual physician's needs. The ACCME also recognizes that physicians are responsible for choosing their own CME and evaluating their own learning achievement. The *Essentials*, therefore, are designed to encourage and foster self-directed physician participation in CME, in which physicians assume full reponsibility for the choice of their CME activities in accordance with their perceived needs, individual preferences of learning methods, and practice settings. Sponsors should take into consideration the needs and interests of potential physician participants in planning their CME activities, and encourage these physicians to assume active roles in the planning process.

In the *Essentials*, the ACCME has identified certain elements of organization, structure, and method which appear to contribute significantly to the development of continuing medical education. They are presented here in the *Essentials for Accreditation of Sponsors of Continuing Medical Education (Essentials)*.

The *Essentials* are made up of those requirements which a sponsor substantially must meet for accreditation. An explanation and rationale also are provided. The *Essentials* should prove valuable as a resource for physicians planning their own CME and for sponsors designing CME programs.

The ACCME will review the *Essentials* on a continuing basis and will modify them as knowledge and experience dictate.

It is important to note that the ACCME does not accredit individual CME activities, but institutions and organizations for their overall program of CME. The overall program consists, at least in part, of one or more educational activities, developed according to these *Essentials*, which provide direct teacher-participant interaction.

The following definitions will be useful in reviewing the *Essentials* and in gaining an understanding of the accreditation process:

Continuing Medical Education (CME): Continuing medical education consists of educational activities which serve to maintain, c velop, or increase the knowled skills, and professional performan and relationships that a physici uses to provide services for patien the public, or the profession. T content of CME is that body knowledge and skills generally re ognized and accepted by the pr fession as within the basic medic sciences, the discipline of clinic medicine, and the provision health care to the public.

This broad definition of CME re ognizes that all continuing educ tional activities which assist phy cians in carrying out their pr fessional responsibilities more effe tively and efficiently are CME. course in management would be a propriate CME for physicians r sponsible for managing a heal care facility; a course in education methodology would be appropria CME for physicians teaching in medical school; a course in practi management would be appropria for practitioners interested providing better service to patien

Not all continuing educational a tivities which physicians may e gage in, however, are CME. Phys cians may participate in worthwh continuing educational activiti which are not related directly their professional work, and the activities are not CME. Continuin educational activities which r spond to a physician's no professional educational need interest, such as personal financi planning, and appreciation of liter ture or music, are not CME.

Purpose of CME Accreditatio To assure physicians and the publ that CME activities meet accepte standards of education.

CME Accreditation: The reco nition accorded eligible institutio and organizations which meet t *Essentials*.

Program of CME: The overall CM program of a sponsor consists of o or more educational activities co sistent with the *Essentials*.

CME Activity: A coherent educ tional offering which is based upo defined needs, and explicit obje tives, educational content, a methods.

*From the Accreditation Council for Co tinuing Medical Education, Office of t Secretary, P.O. Box 245, Lake Bluff, 60044.

A Sponsor: An institution or organization assuming responsibility CME.

A Participant: A physician enged in CME.

The Essentials: The document ich provides information regardACCME accreditation and the ndards which must substantially met for a sponsor of CME to be redited.

Program of CME: Accreditation is nted on the basis of the sponsor's nonstrated ability to plan and iment CME activities in acdance with the *Essentials*. The nsor's overall program may inde occasional CME activities that not fully meet the standards for eds assessment, well-defined obtives, curricular design, and luation. These activities are part the accredited sponsor's overall IE program as long as the spon exercises responsibility for these ivities through its recognized IE administrative unit. The orization should identify those IE activities within its overall pro-um which meet the *Essentials*.

E ESSENTIALS

The following *Essentials* comprise criteria, or standards, by which gible sponsors of continuing dical education are evaluated in ler to determine their qualifiion for accreditation by ACCME.

Essential #1: The sponsor shall ve a written statement of its conuing medical education mission, mally approved by its governing dy. The mission statement shall: describe the goals of the overall IE program in a concise manner; indicate the scope of the CME ef-t; 3) outline the characteristics of potential participants; and 4) deibe the general types of activities d services provided.

n order to provide quality CME, it essential to have a written ssion statement which has been reed upon by the governing body. is statement outlines what is exted of the CME organization and ves as a basis for a more objective luation of its ability to meet its ssion. Without such a document, ere may be misunderstandings as the scope and nature of the CME ivities undertaken. With an reed-upon mission statement, the IE organization more easily can seek needed support from its governing body to accomplish its required functions.

The mission statement identifies what the sponsor desires to accomplish through its overall program of CME. It describes the educational goals of the overall program in terms of content or extended learning, the physicians for whom the educational program is intended, and the general kinds of educational activities and services which will be used to accomplish these goals. It is desirable to relate the educational goals of the overall program, as found in the CME mission statement, to the primary purpose or mission of the sponsor as an institution or organization.

The mission statement should serve as an effective point of reference for individual CME programming and evaluation of the overall program. The mission statement should be reviewed periodically in the light of experience and revised if necessary.

Essential #2: The sponsor shall have established procedures for identifying and analyzing continuing medical educational needs and interests of prospective participants. The sponsor shall: 1) document the processes used to identify CME needs including data sources which go beyond the sponsor's own perception of need, and 2) state the overall needs identified by the above processes and indicate how this assessment is used in planning educational activities.

Identification and analysis of CME needs (needs assessment) provides the basis for formulating educational objectives and planning educational activities. Needs assessment results in a statement specifying instructional intent and/or expected learning outcomes. Needs may be perceived and/or identified by both the physician participant and the sponsor. Setting priorities for identified needs will assist the sponsor in planning educational activities.

Educational needs and interests refer to any knowledge, skill, or attitude that physicians either should or wish to acquire, develop, or reinforce. Participants should be treated as professionals with respect for their knowledge, experience, and self-motivation. Therefore, a goal for every CME activity should be to increase, or at least to maintain, the participants' desire to continue their medical education. This important goal of CME should be kept in mind when designing the activity, i.e. choosing the educational methods, selecting instructors, and determining methods of evaluation. The way that educational subjects are presented, as well as the instructor's manner with participants, influence the motivation of physicians not only to learn during the activity but to continue learning after the activity is completed.

The sponsor may use a wide variety of procedures to identify needs, such as a sample survey interview of prospective participants, analysis of self-assessment examination results, epidemiological data, patient care audit, or a search of current literature or consensus of experts in a particular field. The sponsor should attempt to weigh the relative importance of the needs identified, and determine the planning of CME activities and use of resources with these priorities in mind.

The term "need" usually connotes some degree of necessity or obligation. The necessity or obligation may arise from a physician's sense of responsibility to maintain or improve personal professional activities. This necessity or obligation also may arise from external requirements of some organization or agency such as a licensure board, certifying agency, specialty society, or hospital staff.

The term interest connotes an educational want or desire. Physicians may desire some knowledge, skill, or attitude not perceived as necessarily directly applicable to their medical practice. For instance, a physician may desire to learn more about a particular development in his medical research yet realize that this knowledge may not be the only or primary criterion of choice for physicians.

An educational need may be real yet exist independent of the awareness of the physician. A real need becomes a perceived need when the physician is aware of it. Unless physicians perceive an educational need as their own, any CME activity based on that need is unlikely to be successful in effecting real learning or in attracting participants. If the educational need is real, but unperceived, physicians may need as-

sistance recognizing that need.

An educational need is not the same as a performance need. Needs identified by quality assurance programs, for instance, do not necessarily indicate a lack of knowledge or skill. Sponsors may wish to analyze performance needs to determine whether there is, in fact, a need for physician learning and not assume that performance deficiencies can be addressed successfully through educational activities.

Essential #3: The sponsor shall have explicit objectives for each CME activity. The sponsor shall: 1) state the educational need(s) which the individual activity addresses; 2) indicate the physicians for whom the activity is designed; 3) list any special background requirements of the prospective participants; 4) highlight the instructional content and/or expected learning outcomes in terms of knowledge, skills, and/or attitudes; and 5) make these objectives known to prospective participants.

Clearly stated objectives provide prospective participants with a realistic understanding of the nature and purposes of the CME activity. This allows prospective participants to select educational activities which meet their needs. It also helps sponsors to target educational activities to meet explicit needs. A CME activity which takes place over a period of time, e.g. weekly grand rounds, may be covered by a single set of objectives.

The development of objectives serves three functions: 1) assisting sponsors in planning, designing, and implementing educationally effective activities; 2) assisting sponsors in evaluating the quality of CME activities; and 3) assisting prospective participants in judging whether or not a CME activity meets their needs or interests. The adequacy of a sponsor's development of objectives depends on how well these objectives fulfill these three functions.

Explicit objectives means that the objectives are clear and of sufficient detail so that they are capable of fulfilling the three functions outlined above. Objectives need not be overly detailed.

These objectives should relate to the needs identified in Essential #2. Such needs might include updating existing medical knowledge or technical skills, the learning of new concepts or methods, or the sharing of new ideas and experiences to stimulate the development of knowledge or skills.

An objective that is conceived properly and is stated clearly constitutes an important link in the educational chain. Good objectives are formulated from identified needs or interests and written in terms that facilitate evaluation. Clear objectives aid in judging the success of the CME activity.

In contrast to goals, which are general and long-range, objectives are specific, short-range, and more action-oriented. Objectives may be defined with respect to instructional content, levels of knowledge or performance, degrees of skill or technique, and changes in attitude or behavior relating to patient care that are the desired results of the CME activity.

Keeping one or more of the following questions in mind may help in developing good objectives: Will attainment of these objectives meet the identified needs? What will the participants be expected to know or be able to do as a result of the CME activity? How is the participant's attitude or behavior expected to change? How do these relate to patient care or other professional activities? Can attainment of the objectives be measured or evaluated?

The *Essentials* place great importance on the principle that physicians are responsibile for choosing their own CME, in accordance with their perceived needs, preferred learning methods, and practice settings. In accordance with this principle, sponsors may make known to prospective participants the objectives of the activity, indicate the physicians for whom the activity is designed, list any special background requirements for effective participation, and state the educational methods that will be used. This information should appear on promotional materials and printed programs. Individual educational objectives need not be stated for each part or unit of an activity if the objectives are apparent or if they are summarized in the CME activity description.

Each CME activity should be described in terms of the broad or specific groups of physicians for whom it may have value. For example, a particular CME activity ma intended to bring a new med concept to the attention of an en specialty group or to a range of lated specialty groups, or it migh a more limited concept intended a subspecialty group.

A prospective CME particip should be informed as to the le of skill or knowledge required for participation in, and compreh sion of, each CME activity. For stance, it may be suggested t each participant review a spec area of regional anatomy before ticipating in a CME activity in or to better comprehend the spec surgical procedure or diagno technique to be introduced or cussed. One also might be reque to review the broad classificatio tumors of a specific area in p aration for a better understand of the more detailed presentatio the management of tumors of area.

When parts or units of a CME tivity are integrally related to the tire activity, one set of object may be sufficient. This app whether the parts or units of an tivity are united in time, e.g. a th day conference, or appear as disti units over a period of time, e.g. gr rounds.

Essential #4: The sponsor s design and implement educatio activities consistent in content method with the stated objecti The sponsor shall: 1) design and plement educational activities sponsive to the characteristics prospective participants, such knowledge levels, professional perience, and preferred learn styles; 2) document use of syst atic planning procedures; and make educational content methods known to prospec paticipants.

After the identified needs h been translated into explicitly sta educational objectives it is imp tant to design and implem educational activities in a way t facilitates meeting the objecti The selection and organization content, and decisions about edu tional formats, methods, media, a faculty should be based upon w seems most effective and efficien meeting these objectives. Th same elements pertain to sponso CME activities which provide in mation and assistance to physici

ngaged in self-directed learning.

The term sponsor is comprehensive, referring to the institution/organization accredited for its verall CME program. Implicit in the se of this term is the fact that a umber of people with different esponsibilities may be involved in ne design and implementation of ne CME activities that comprise the ME program. A group that is representative of the institutional/ rganizational membership (usually esignated the education committee) usually has responsibility for ne operational aspects of the CME rogram.

Design and implementation of ME activities implies systematic lanning. Planning of any CME activity, ranging from a one-hour conference to a multiday symposium, nvolves a sequence of tasks, with ach successive step depending pon completion of the previous ne.

An initial step should be to review valuation data from previous simir CME activities when available.

A major consideration is the haracteristics of prospective paricipants, i.e. for whom the CME activity primarily is intended/deigned, viz. certain specialists or the ntire medical staff. After identifying he target group, one should make reliminary assumptions regarding articipants' current knowledge evels in the subject matter, past proessional experiences, and types of earning methods appropriate for hat group and subject.

A closely related task is needs ssessment (Essential #2), i.e. "Why s this CME activity being held?" Whatever the method used to identify needs, the assessment should letermine whether acquisition of nformation, knowledge, or skill is he basic need, or whether a review/refresher, an update, or presenation of new concepts is required.

A next and important step is the levelopment and statement of objecives for the CME activity (Essential #3). There should be a clear, concise tatement of what the participants hould learn and/or be able to do as result of the CME activity. Such a tatement, evolving from the revious planning activities, rovides a useful focus for the paricipants and for the teachers. This specially can be valuable when here are many and varied CME activities available to the physician. For the teacher, it should determine preparation and selection of teaching methods.

Selection of faculty, i.e. the person(s) who will be invited to conduct the CME activity, is determined by several factors: foremost, the availability of competent and enthusiastic individuals; the level of expertise required; the extent of preparation necessary; and available resources. Good faculty often can be identified with one's own organization. External faculty should be selected to meet the defined objectives and not primarily for their charisma.

Effective planning requires that the format and educational methods be appropriate to the objectives. Sufficient time should be allocated for faculty and participants to accomplish the objectives. Optimal opportunity should be given to participants to be involved actively in implementation of the CME objectives.

Evaluation of the activity (Essential #5) is an integral part of the planning and should be incorporated into the design. Whether the activity is simple or complex, or short or long, some form of evaluation should be planned. At a minimum, participants should provide feedback regarding achievement of the objectives, i.e. were CME needs met. Additionally, effectiveness of the educational method, the faculty, and other aspects of the activity can be critiqued. Evaluation completes the process cycle and should lead to refinements in planning for future CME activities.

Other tasks pertain more directly to implementation of CME objectives and include scheduling, arrangements for facilities, and audiovisual equipment/services preparation of educational materials, i.e. handouts, slides, and transparencies. Decisions regarding these aspects should be made in collaboration with, and under the guidance of, the person(s) responsible for the CME program.

The *Essentials* encourage and foster self-directed learning in the sense that physicians actively should be responsible for their own continuing medical education. Physicians are encouraged to identify their own educational needs and interests and to develop plans to meet these needs and interests. Effective planning for a self-designed educational program would include the elements of identification of need, development of educational objectives, choice of appropriate educational activities, and evaluation. The educational activities chosen may include a variety of forms, from reading to formally organized courses. A time schedule for completing the self-designed program is highly advisable.

Some physicians may desire assistance in developing self-designed educational programs. Consultation with those experienced in planning CME activities, experienced medical librarians, or physician specialists may be helpful. Sponsors may wish to offer assistance to physicians in developing "self-directed" individual CME programs. Sponsors who have the resources may desire to offer this assistance and are encouraged to do so.

Documentation of the systematic planning procedures is an integral part of an institutional/organizational CME program. Again, whether regularly-scheduled intrainstitutional activities, periodic conferences, courses, seminars, symposia, or workshops, it is useful to have a written record of education committee or other planning group meetings; correspondence relating to faculty, facility, financial arrangements, as indicated; needs assessment; objective-setting; and evaluation. Such documentation need not be complicated or time-consuming, but should be sufficient for the particular CME activity. Patently, this information and related data are valuable in monitoring the overall program, ensuring continuity, planning future CME activities, and as evidence of fulfillment of requirements for continued accreditation.

Prospective participants should be informed in advance about the specific content and format for a CME activity, for several reasons: 1) it enables them to select CME content that is relevant to their needs and/or interests; 2) in locales where many CME offerings are available, advance information allows the physician to choose activities that are best suited to personal needs and time allocation; 3) when some preparation is desirable or required, this can be accomplished, thereby enhancing the extent and value of participation; 4) they will know the

extent and type of participation expected of them; and 5) in some respects, this information represents truth in advertising. Physicians who are uninformed or misinformed will be disgruntled, with the result that they may not participate in future activities. Advance publicity reflects proper planning and conveys a favorable impression to the physician regarding the potential worth of the CME activity.

Essential #5: The sponsor shall evaluate the effectiveness of its overall continuing medical education program and component activities and use this information in its CME planning. The sponsor shall: 1) periodically review the extent to which the sponsor's CME mission is being achieved by its educational activities; 2) show that these evaluations assess: the extent to which educational objectives are being met; the quality of the instructional process; participants' perception of enhanced professional effectiveness; 3) use evaluation methods which are appropriate and consistent in scope with the educational activity; and 4) demonstrate that evaluation data are used in planning future CME activities.

The systematic gathering of evaluation data and their analysis, including evaluation of individual CME activities, is necessary for the sponsor to assess the degree to which the overall program fulfills its CME mission. It also will guide the planning of future activities and permit rational decisions about improving the educational program.

This Essential requires that the sponsor periodically review the extent to which the sponsor's educational goals for the overall program of CME, as contained in the mission statement, are being achieved. The sponsor should do this annually. In order to evaluate the effectiveness of the overall CME program, the sponsor must evaluate individual CME activities which have been planned and conducted. These evaluations must assess the extent to which the educational objectives have been met, the quality of the educational process, and the participants' perceptions of enhanced professional effectiveness.

Evaluation methods must be appropriate and consistent in scope with the educational activity. A well-constructed evaluation form completed by participants at the conclusion of the educational activity provides useful data. Often the evaluation form also provides an opportunity for participant suggestions for future educational activities. Immediate indepth evaluation by selected participants, as well as followup surveys, may be very helpful.

If the educational objective concerns the learning of a skill, direct observation of the participant's ability to perform that skill is an excellent method of evaluation.

Tests may be used when appropriate. It is difficult, however, to construct a valid and reliable test, and as a result, data from tests often are questionable. The sensitivity of participants should be considered. Care should be taken that testing does not adversely affect the physician's desire to continue learning.

Although the ultimate purpose of continuing medical education is to improve medical care, measurements of physician performance, the quality of medical care and patient outcomes should not be the only criteria used in assessing the quality of the educational activity and of the degree of learning by participants. While keeping in mind that many factors beyond the control of CME planners influence medical care, sponsors are encouraged to attempt to assess the effect of their CME activities on medical care when this is feasible.

There are other evaluation techniques that are not based on educational objectives, but may be useful to the sponsor. Participant attention and enthusiasm, active involvement in discussion, the kinds of questions asked and comments made for instance, may be observed and recorded. The number of physicians who voluntarily return to a sponsor's CME activity may be another indication of quality.

The *Essentials* require that the sponsor demonstrate that evaluation data are used in planning future CME activities. Evaluation data collected but not used in future planning are worthless.

Essential #6: The sponsor shall provide evidence that management procedures and other necessary resources are available and effectively used to fulfill its continuing medical education mission. The sponsor shall: 1) document an organizational structure for CME and its administration, designating an entity re sponsible for CME and delineatin its authority; 2) identify responsibl individuals who will maintain cont nuity of administration; 3) describ an internal review and contr procedure, including budgetar practices, to ensure effective utiliza tion of resources in fulfilling th CME mission; 4) provide a budge for the overall CME program and it major components; 5) utilize compe tent faculty; 6) provide appropriat facilities for CME programs; and 7 have mechanisms to record an when authorized by the partic pating physician, to verify partic pation.

Whether sponsors of CME ar large or small, adequate manage ment and control are necessary t assure quality educational activities In addition, adequate resource must be available in order for CM activities to be relevant, effectiv and efficient for physicians.

Administration—The sponso must document an organizationa structure for CME and its adminis tration, designating an entity re sponsible for CME and delineatin its authority. This entity may be a individual or a committee. If an indi vidual is designated, there should b an advisory committee, with a ma jority of physicians, which takes a active role in planning. Minutes o committee meetings should be kept CME committees should have rep resentation of departments and/o services when appropriate an feasible.

The organizational structur must clearly indicate the authorit of the entity responsible for CME and should show how this entity re lates to the governing body of th organization and effectively super vises CME planning of other units o the organization. CME policies an procedures should be documented

There should not be undue de pendence on one individual so tha in the event of absence or illness, th CME program flounders. The spon sor must identify responsible indi viduals who will maintain conti nuity of administration. Members o committees should be appointed s their terms expire on varying dates Administrative staff support shoul be sufficient to fulfill the CM mission. The terms of office of th persons responsible for CME shoul

e of sufficient duration to assure ntinuity of administration.

Utilization of Resources—To nsure effective utilization of re-ources in fulfilling the CME ission the sponsor must have an nternal review and control rocedure. This procedure need not e elaborate. The procedure should ermit the entity responsible for the verall program of CME to effectively onitor and supervise the planning nd implementation of individual ME activities.

Included in the internal control rocedure is preparation of a budget nd the use of sound fiscal practices administering the overall CME rogram. The budget should be ade-uate to meet the objectives of the ission statement. The sponsor is ncouraged to have a separate CME udget, but should be able at least, early to identify the CME budget hen not separate from other items. ndividual departments or services an organization may have their vn CME budgets, but the entity re-ponsible for the overall CME pro-am should have some responsi-lity for the allocation and utiliza-on of resources.

Competent Faculty—The sponsor ust utilize competent faculty. Fac-ty for a CME activity should be lected not only for their knowledge the subject matter, but for their ility to communicate and to facili-te learning. The faculty's attitudes nd manner of treating participants e also important considerations.

Appropriate Facilities—Sponsors ust provide appropriate facilities and materials for CME activities. Appropriate means conducive to learning. As an example, access to an adequate, up-to-date library and audiovisual facilities are important.

Facilities may be selected for a CME activity at a site which offers opportunities for recreation and relaxation. These opportunities should complement, rather than detract from, the CME activity itself. Publicity should present the CME activity as the major incentive to physicians who may choose to participate.

Records of Attendance—The sponsor must have a mechanism to record physician participation at CME activities. Records should be kept for at least six years. Sponsors must have a mechanism to verify physician attendance when authorized by the participating physicians.

Essential #7: The sponsor shall accept responsibility that the *Essentials* are met by educational activities which it jointly sponsors with nonaccredited entities. The sponsor shall: 1) provide evidence that it participates integrally in the planning and implementation of each jointly sponsored CME activity; and 2) conduct an evaluation of each jointly sponsored CME activity.

An accredited sponsor may be asked by organizations which are not accredited to jointly sponsor CME activities, so they may have accredited sponsorship. When an accredited sponsor agrees to joint sponsorship it must provide assurance that the *Essentials* are met.

The *Essentials* require that a sponsor accept responsibility that accreditation standards are met by CME activities it jointly sponsors with nonaccredited institutions and organizations. An accredited institution or organization has the same responsibility for an activity it jointly sponsors as for an activity it sponsors. The sponsor should provide information on these jointly sponsored activities when resurveyed for accreditation and must demonstrate that it has participated integrally in the planning and implementation of these activities.

Jointly sponsored activities must be consistent with the sponsor's mission statement. The sponsor must conduct an evaluation of each jointly sponsored CME activity in the context of its mission statement.

The name of the accredited sponsor should appear on all promotional materials and on the printed program of the jointly sponsored activity. If more than one accredited sponsor jointly sponsors a CME activity, one should assume responsibilty for the activity and this should be indicated clearly on the promotional materials and printed programs.

Some local chapters or affiliates of national organizations neither are independently accredited nor specifically included in the accreditation of the national organization. The accredited national organization should have care that it not be listed as the joint sponsor of CME activities of such local chapters or affiliates unless the requirements of this Essential are met.

LETTERS TO THE EDITOR

Child Find;
Mandatory Assignment

Child Find

April 11, 1984

Dear Doctor Krosnick:

A statewide CHILD FIND system to identify unserved handicapped children from birth through 21 years of age recently has been re-established by the New Jersey Department of Education in the Regional Curriculum Services Unit-Central, 75 Racetrack Road, East Brunswick, NJ 08816. The activities of CHILD FIND include the operation of a toll-free hotline (800-322-8174) to respond to parental and professional requests for assistance and to act as a clearinghouse for information regarding programs and services for handicapped children in New Jersey.

Project CHILD FIND provides the most up-to-date information on programs and services available for handicapped or potentially handicapped children throughout New Jersey. All phone calls are handled in an efficient and confidential manner to facilitate appropriate services for all inquiries. Project CHILD FIND also has outreach and media information prepared for distribution in its efforts to comprehensively seek out children in need of special services.

I would welcome any questions you or your readers may have regarding Project CHILD FIND and gladly will forward specific printed information you may require. The toll free number operates from 8:30 A.M. to 4:30 P.M. Monday through Friday.

(signed) Frances Stromsland
CHILD FIND Project Coordinator

Mandatory Assignment

May 4, 1984

Dear Doctor Krosnick:

Thursday, April 12, 1984, was a crucial day for American medicine. On that day, the AMA fought back an attempt to impose involuntary servitude by the government upon every practicing physician in the United States.

If mandatory assignment had passed, you would have been required to sign an agreement with your hospital to accept Medicare assignment for all inpatient care or lose all staff privileges. In effect, you would not have been able to work at your profession.

If it had not been for organiz medicine, that would be your plig today. If it had not been for the v untary freeze in fees, a mandato freeze now would be in effect.

This incredible effort to preve your financial enslavement mu not go unnoticed by you. Any doc who does not belong to the A should not let this day pass witho writing out a check for his du What a small price to pay for th service to you.

On the local level, the outstandi work of Morton Farber, M.D., mu be brought to your attention. heeded the call for assistance at l county society office and spent l day off making telephone calls a sending telegrams to other docto hospital administrators, and to c gressmen to prevent this devast ing legislation from being pass Jean Bruno was county represen tive on a state auxiliary delegati who spent Wednesday, April 11, a Thursday, April 12, in Washingt visiting congressmen and spreadi our message.

It was doctors like Morton Farb spouses like Jean Bruno, and ganized medicine who made the d ference. The war is not over, bu significant battle has been won. Y will share in the fruits of that v tory. In good conscience, you mu share the cost.

In order to build on what we ha won, we should honor the fee fre requested by the AMA and your st and county societies. It is our tu to send a message to the Americ people. Let us not fail.

(signed) Donald J. Holtzman, M.
President, Union Cou
Medical Soci

Annual Review of Nutrition; Annual Review of Neuroscience; Arthroscopy; Colour Atlas of Diabetes; Varicose Veins, Related Diseases, and Sclerotherapy

nnual Review of utrition, Volume 3

lliam J. Darby (ed). Palo Alto, CA, nual Reviews, Inc., 1983. Pp. 478. ustrated. ($27)

This latest in a recently estabhed Annual Reviews series meares up to the esteem in which the entific community holds their n biologically and/or biomedically ented series. The Annual Reviews itors never have feared to break w ground, the present volume ing no exception, as attested by e "prefatory essay" by Madeleine P. smar of the Institute for Medieval d Renaissance Studies, City Colge, City University of New York. e essay, "A Feast for Aesculapius; storical Diets for Asthma and Sexl Pleasure," is delightfully illstrated by medieval woodcuts. aimonides, center stage, recmmends that a severe asthmatic ould prophylactically precede loveaking with hot clear chick soup. W.T. Jarvis succinctly covers food ldism, cultism, and quackery, cumenting the dismal impression at P.T. Barnum was right. The folving items are exceptionally timeand critical: biological activity of enium (R.F. Burh); absorption d metabolism of dietary choles'ol (S.M. Grundy); placenta in trition (S.J. Pilistine and M.E. Fant); nutrition in renal failure (M. Walser); ischemic heart disease and lipids in blood and diet (R.A. Stallones); endocrine responses to protein-calorie malnutrition (D.J. Becker); availability of trace elements (R.M. Forbes and J.W. Erdman, Jr.); carnitine (P.R. Borum); normal and abnormal Cu and Zu metabolism (R.A. DiSilvestro and R.J. Cousins); niacin (L.M. Henderson); stable-isotope methods in nutrition research (D.E. Mathews and D.M. Bier); endemic goiter and cretinism (J. Matovinovic); individual food consumption in the U.S. (P.B. Swan); and protein metabolism and injury (J.M. Kinney and D.H. Elwyn). Herman Baker, Ph.D.

Annual Review of Neuroscience, Volume 7

W. Maxwell Cowan (ed). Palo Alto, CA, Annual Reviews, Inc., 1984. Pp. 494. Illustrated. ($27)

This book is the seventh in a series of annual reviews of progress in the neurosciences. Thirty-six authors present 17 individual papers on different topics, each of which deals in detail with a single area of neuroscience research. Their subjects are almost exclusively in the basic neurosciences, so that little of a clinical nature is covered. Some examples are discussions of neuronal growth factors, proteolysis of neuropeptides, intracellular H+ mechanisms, and cell adhesion in the nervous system. Most of the papers include historical background and recent advances as well as divergent current opinions and theories about each subject.

A few papers will prove of interest to the practicing neurologist or neurosurgeon. One deals with the endorphins, enkephalins, and dynorphins, and their related neuropeptides and opioid receptors in relation to stress, analgesia, and cardiovascular control. The authors describe the complexity of biochemical and physiological interrelationships of these substances as "dizzying," and admit that potential interactions seem infinite. Other somewhat more clinical papers discuss the neural basis of language, intracellular neural implants, endogenous pain control systems, and withdrawal from opioid drugs.

These reviews are very complete and well done. They impress one with the complexity and sophistication of current neuroscience research, but are chiefly oriented to basic sciences. This book is heavy reading indeed for the average practitioner.

Stanley C. Leonberg Jr., M.D.

Arthroscopy: Diagnosis and Surgical Practice

S. Ward Casscells, M.D., (ed). Philadelphia, PA, Lea & Febiger, 1984. Pp. 192. Illustrated. ($40)

The contributing authors to this compendium of arthroscopic knowledge will be well known to orthopedists who became interested in this aspect of their specialty several years ago, when the American Academy of Orthopaedic Surgeons sponsored courses on the subject. A hardy nucleus of the pioneers in this field were present as faculty, and one saw virtually the same faces, no matter where he went to study arthroscopic surgery. These teachers have recorded their remarks in the form of textbook chapters, brought together by the course chairman, S. Ward Casscells.

Like the courses which preceded the book, and like all texts compiled in this fashion, the outcome rarely is fully satisfying. That is not to say that the book is without merit. Because the contributions are individual efforts, there tends to be a lack of cohesiveness, and the process leaves gaps and creates redundancies, as when, for example, the "fish-mouth" tear of the meniscus is described and diagramed by Drs. Zarins and McInerny in chapter 6, and again by Dr. Metcalf in chapter 17.

The first half of the book is theoretically devoted to diagnostic arthroscopy, but in chapter 5, Dr. Casscells wanders into a brief discussion of abrasion arthroplasty, a surgical technique, and appears to dismiss its effectiveness. This procedure is advocated by Lanny Johnson who notably is absent from the list of authors, and who perhaps deserves an opportunity to defend it in a book described by the publisher as "comprehensive." Synovial disease is discussed in chapter 4, and synovectomy in chapter 5, but there is no reference to, or description of, any technique for accomplishing synovectomy arthroscopically,

although others, including one of this book's contributors (Dr. Metcalf), have advocated that method.

Patellofemoral joint disorders are discussed in the diagnostic section of the book and by Drs. Shybut and McGinty in the surgical chapters. In neither place can one find a description of the portals used in evaluating patellofemoral joint mechanics, or of the normal and abnormal findings in those conditions affecting patellofemoral dynamics, except for mention of the percentage of lateral patellar overhang. Well before the date of publication of this book, the use of superior portals to evaluate patellofemoral contact during flexion and extension was well documented.

One might expect that in a book such as this, the chapter in the section on arthroscopic surgery by Dr. Kenneth DeHaven on peripheral meniscus repair would discuss arthroscopic techniques. Yet, arthroscopy was used only for diagnosis, and Dr. DeHaven then proceeds to describe an open procedure for meniscal suture. One brief comment is the sole reference to closed meniscal repair: "It is likely that these procedures will be performed arthroscopically in the future." Yet, the tools and instruments exist, and other arthroscopists have described the approach and produced teaching material.

R.W. Jackson, M.D., another of the pioneers, writes in his foreword that this book is "truly a state-of-the-art publication." Unfortunately, as in computers and other "high tech" fields, what is state-of-the-art today, is obsolete either tomorrow, before delivery, or publication date.

In this book, the degree of obsolescence appears to depend on how long it has been since the author updated his chapter's material after joining the lecture circuit. Dr. Glick's chapter on the use of the laser beam looks to the future. The remainder of the book is a look backwards, by people who clearly have earned the right to do so, and from whose observations all surgeons doing arthroscopic procedures can learn. The drawings clearly illustrate the points to be emphasized, and the photographs of arthroscopic pathology are clear and very well reproduced.

I recommend this book especially to the student arthroscopist, but also to those with an established interest in the field, with the caveat that is not the last word on the subject. No observer of so rapidly advancing a field should expect a text to be that.

Robert A. Goldstone, M.D.

A Colour Atlas of Diabetes

Arnold Bloom, M.D., and John Ireland, M.D. Chicago, IL, Year Book Medical Publishers, Inc., 1980. Pp. 119. Illustrated. ($55)

This is not a textbook of diabetes, but a presentation in graphic form of the clinical and histological manifestations of this disease. The authors have divided their atlas into ten chapters starting from etiology, through manifestations, pathology, and complications. They do not deal with management of diabetes.

In British fashion, the text is terse, pithy, yet quite comprehensive—each chapter followed by excellent photographs in color. Particularly striking are the photographs of the eye and kidney pathology. While this volume will not meet a student's requirement for a textbook of diabetes, the many pictures can be a valuable supplement in the study of this il ness.

Samuel E. Einhorn, M.I

Varicose Veins, Related Diseases, and Sclerotherapy: A Guide for Practitioners

H.I. Biegeleisen, M.D. Montrea Canada, Eden Press, 1984. Pp. 24 Illustrated. ($35)

"A new branch of medicine tha requires special knowledge, trai ing, and skill for its practice" refe to sclerotherapy as applied to va icose veins, its complications, an other related diseases. According t the author, this is the first manu of its kind that deals with all know sclerosing techniques as personall practiced for the last 50 years. Th pervading theory throughout thi labor of love is that all disorders re lated to inherited fascial defects an accompanied by tissue weaknes and degeneration best are treated b sclerotherapy. Headed by varicos veins, the list includes stasis ulcer lymphedema, hemorrhoids, rect prolapse, pilonidal cysts, hydrocele hernias, low back syndromes, and host of others. Repetitious descrip tions of sclerosing agents and tech niques as applied to scattered ana tomical sites were weakly enhance by suboptimal illustrations. Th bibliography also is extended by rep etition.

Dr. Biegeleisen should hav heeded his comment "Although thi manual was first written 40 year ago, it never was published becaus it soon was rendered obsolete." Thi guide for practitioners is perhap more of historical interest rathe than practical.

Joseph Alpert, M.I

OBITUARIES

Drs. Bernhard; Birnbaum; Drossner; Hill; Leach; Mancene; Rocco; and Saul.

Dr. Joel A. Bernhard

Joel A. Bernhard, M.D., a member of our Essex County component, died on February 27, 1984. Born in 1900, Dr. Bernhard was graduated from Jefferson Medical College, Pennsylvania, in 1940. An anesthesiologist, Dr. Bernhard was affiliated with the Hospital Center, Orange. Dr. Bernhard was a member of the American Medical Association.

Dr. Leo Birnbaum

At the grand age of 89, Leo Birnbaum, M.D., a retired physician of our Union County component, died on January 14, 1984. Born in New York City, Dr. Birnbaum received his medical degree from New York Medical College in 1931. Prior to establishing a practice in psychiatry in Scotch Plains, in 1964, he had been a general practitioner in Sunnyside, New York and had served on the staff of various Veterans Administration facilities throughout the United States. Dr. Birnbaum was a Diplomate of the American Board of Psychiatry and a Fellow of the American Psychiatric Association. He retired from the active practice of medicine in 1975 and had been living in California until his final illness.

Dr. Jacob L. Drossner

Jacob Louis Drossner, M.D., an internist for 42 years prior to his retirement in 1979, died on April 20, 1984. Born in 1913, in Philadelphia, Dr. Drossner received his medical degree from the University of Pennsylvania's School of Medicine in 1936, graduating first in his class. He established a practice in his specialty in Camden; in 1961 he moved to Pennsauken. Dr. Drossner had been affiliated with Cooper Hospital, Camden, and Garden State Hospital, Marlton. He was board certified in internal medicine, was a member of the American Medical Association, a member of our Camden component, and an associate professor at Thomas Jefferson University, Philadelphia. He served in the medical corps of the Army of the United States, and received the Silver Star and the Purple Heart.

Dr. Clarence T. Hill

Clarence T. Hill, M.D., a general practitioner in Rahway for over 40 years prior to his retirement in 1973, died on March 30, 1984. Born in Madison, Dr. Hill received his medical degree from Howard University College of Medicine in 1932. He had been on the staff at Rahway Memorial Hospital, and was a member of the American Medical Association and of our Union County component. Dr. Hill was 81 years of age at the time of his death.

Dr. John E. Leach

A Paterson physician for 41 years, John E. Leach, M.D., died on April 7, 1984. Born in 1908, Dr. Leach earned a medical degree from Jefferson Medical College, Philadelphia, in 1933. Affiliated with Valley Hospital, Ridgewood, and Chilton Hospital, Pompton Plains, Dr. Leach was an internist. A member of our Passaic County component and of the American Medical Association, Dr. Leach was a Diplomate of the American Board of Internal Medicine and a Fellow of the American College of Physicians.

Dr. Edward M. Mancene

One of the Bergen's County's senior members, Edward Michael Mancene, M.D., died on April 22, 1984. A native of New Jersey, born in 1906, Dr. Mancene was graduated from New York Homeopathic Medical College in 1934. He practiced general medicine in Little Ferry for 50 years until his retirement in 1976. Dr. Mancene was affiliated with Hackensack Medical Center where he had been associate director of the department of family practice. He was a Fellow of the American Academy of Family Practice, and had been a member of the American Medical Association. Dr. Mancene served as a delegate to the Medical Society of New Jersey's House of Delegates for 20 years. He had been active in community affairs, serving as Little Ferry's school physician for 13 years; surgeon to the police and fire departments; and advisory physician to the first aid corps for 35 years. Dr. Mancene also had been vice president of the Little Ferry board of health. During World War II he served with General George Patton's Third Army and was awarded a Silver Star and five bronze stars for valor.

Dr. Leo C. Rocco

A member of our Monmouth County component, Leo C. Rocco, M.D., died on February 25, 1984. Born in 1909, Dr. Rocco earned a medical degree from Creighton University School of Medicine, Nebraska, in 1935. A surgeon, Dr. Rocco was affiliated with Riverview Hospital, Red Bank, and Monmouth Medical Center, Long Branch.

Dr. Maslah Saul

At the age of 62, Maslah Saul, M.D., a member of our Cumberland County component, died on March 22, 1984. Dr. Saul was a graduate of the Faculty of Medicine University of Paris, France in 1952. A family practitioner, Dr. Saul was affiliated with the State School Hospital, Vineland.

AUTHOR INFORMATION

Style Sheet

The Journal is the official organ of the Medical Society of New Jersey. The goals of* The Journal *are educational and informational. All material published in* The Journal *is copyrighted by MSNJ.

CONTENT

The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports based on unusual clinical experiences; review articles; clinical notes, succinct items on some aspect or new observation or technique of a case experience; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update; and an opinion column. Editorials are prepared by the Editor and by guest contributors on timely and relevant subjects; editorials are the responsibility of the author. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the Editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made in New Jersey.

ASSIGNMENT OF COPYRIGHT

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978), a transmittal letter or a separate statment accompanying material offered to *The Journal* of the Medical Society of New Jersey must contain the following language and must be signed by all authors:

"In consideration of *The Journal* of the Medical Society of New Jersey taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *The Journal*, MSNJ."

SPECIFICATIONS

Submit two **manuscripts** that must be typewritten and double-spaced on 8½" by 11" paper. Statistical methods used in articles should be identified. Acknowledgements will be made only for specific preparation of an essential part of the manuscript.

Authors are asked to seek clarity, accuracy, and originality; attention to details of grammar, spelling, and typing are important.

The **title page** should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

The author should submit a 40-word **abstract** to be used at the beginning of the article.

Tables must be typewritten and double-spaced on separate 8½" by 11" sheets, with a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source; written permission for republication from the original publisher must be submitted. The cost of color photographs must be borne by the author.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

The **summary** of the article should not exceed 250 words; it should contain only essential facts.

References should not exceed 35 citations except in review articles and should be cited consecutively in the text by numbers in parentheses at the end of the sentence. The reference list should be typewritten and double-spaced on separate 8½" by 11" sheets in the numerical order in which they are first cited in the text. The style of reference is that of *Index Medicus:*

1. Goldwyn RM: Subcutaneous mastectomy. *J Med Soc N.* 74:1050-1052, 1977.

2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis.* New York, NY, McGraw-Hill, 1969, pp 42-48.

PUBLICATION POLICY

Receipt of each manuscript will be acknowledged and a copy delivered to the Editor who refers the paper to one or more members of the Editorial Board. The final decision is reserved for the Editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. Galley proofs will be submitted to the author for correction of typographical errors.

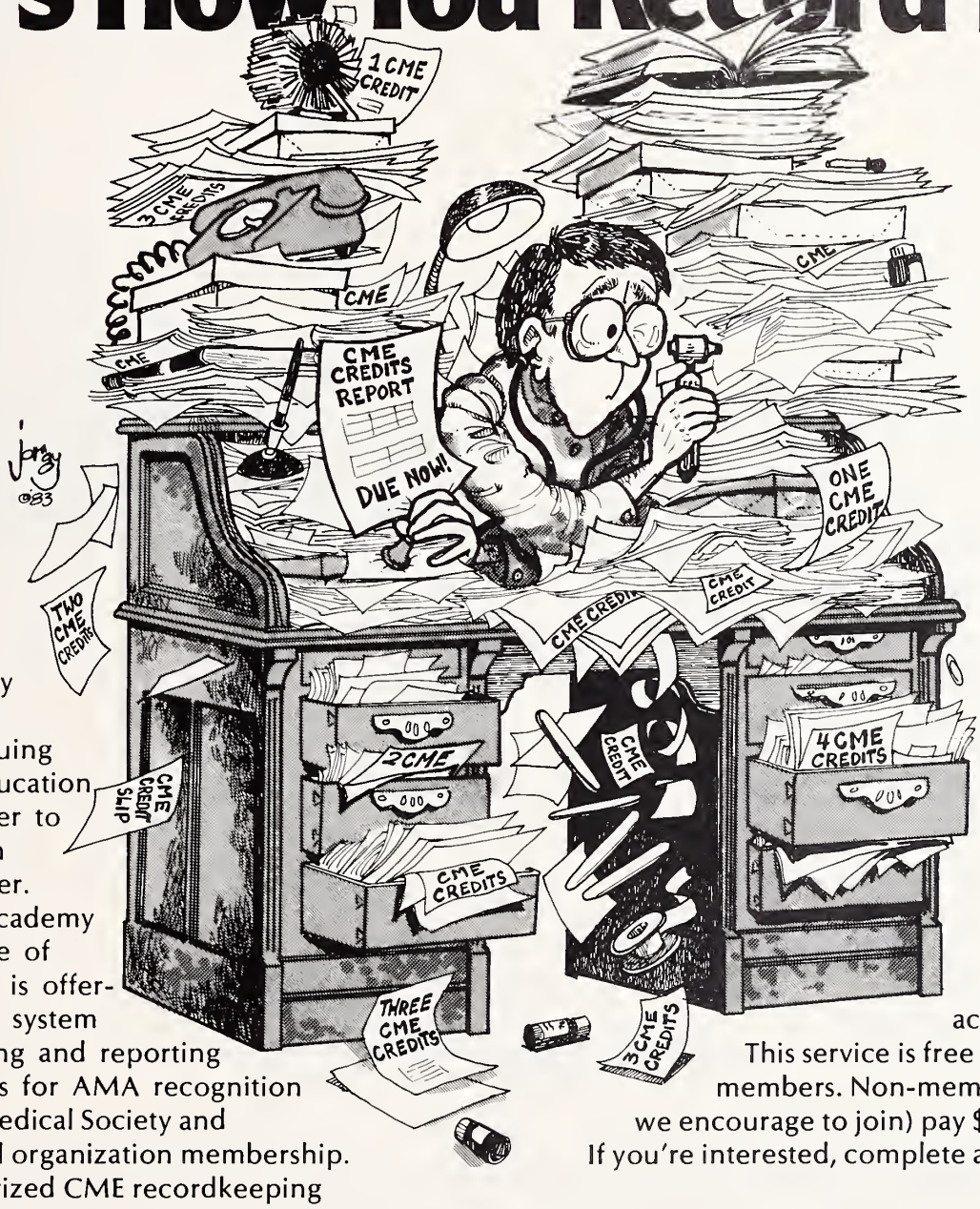
REPRINT ORDERS

Reprints may be ordered after the author is notified that the article has been selected for a specific issue of JMSNJ. A check for the cost of reprints including remake charge if order is received after due date must accompany the order.

COMMUNICATIONS

All communications should be sent to the Editor, *The Journal* MSNJ, 2 Princess Road, Lawrenceville, NJ 08648.

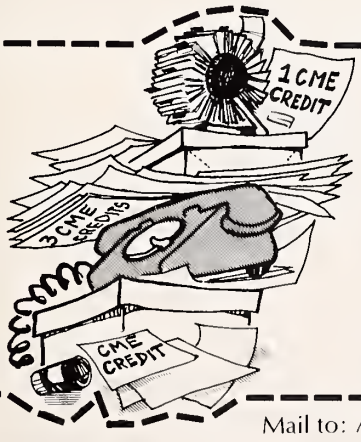
It's Not What You Know, It's How You Record It.



Most busy physicians find continuing medical education credits easier to collect than to remember.

So the Academy of Medicine of New Jersey is offering an easy system for recording and reporting CME credits for AMA recognition as well as Medical Society and professional organization membership. A computerized CME recordkeeping system is available to every New Jersey physician. All you do is send us a reporting card (which your office staff can complete). We'll keep your records and keep you informed semi-annually of your accumulation. This service is free to Academy members. Non-members (whom we encourage to join) pay $30 per year. If you're interested, complete and mail this coupon.

Note: The Medical Society of New Jersey accepts these CME Reports as documentation to meet CME membership requirements.



Please register me for AMNJ's computerized CME record-keeping service.

Name _____

Address _____

City _____ State _____ Zip _____

Telephone Number _____

Your New Jersey Medical License No. (five numerical digits only)_ _ _ _ _

Academy member: Yes ☐

No ☐ Please enclose check

Interested in Academy membership: Yes ☐ No ☐

Mail to: Academy of Medicine of New Jersey, 2 Princess Road, Lawrenceville, NJ 08648

MEDICAL COMPUTERS
DEC - IBM - TELEVIDEO

THINKING OF COMPUTERIZING YOUR PRACTICE?
FBL MEDICAL COMPUTER SPECIALISTS offers a wide variety of hardware/software configurations for every medical office size and application.

- AUTOMATIC INSURANCE FORM PREPARATION
- ACCOUNTS RECEIVABLE CONTROL
- AUTOMATIC PATIENT RECALL
- PRACTICE MANAGEMENT REPORTS
- CLINICAL RECORDS
- APPOINTMENT SCHEDULING
- ELECTRONIC CLAIMS SUBMISSION
- WORD PROCESSING
- MEDICARE/MEDICAID BILLING
- GENERAL LEDGER

FREE OFFICE ANALYSIS AND CONSULTATION — NO OBLIGATION

FBL

PROVIDING YOU WITH OVER 15 YEARS OF MEDICAL COMPUTER EXPERIENCE

3 ROUTE 46W, FAIRFIELD, N.J 07006 201-882-9210

OFFICE SPACE

1250 sq. ft. office on first fl. of 400 unit a complex. Will partition to suit, 4 parking spac included, all utilities paid. Prime Boulevard E location on Palisades. $2300 1 month, c 201-869-2121.



OFFICE/HOME FOR SALE

Princeton Area-West Windsor—Oversized Colonial w seperate office consisting of 2 treatment rooms, wait room, nurses station, lab & bathroom. Room for pension. Excellent traffic. WEICHERT REALTO Princeton, N.J. 609-921-1900

PAGE REFERENCES

Computers, Medical Management 531, 560-561, 571
CME, Seminar 538, 596
Financial 539
Insurance ..... Cover II, 562, 575
Medical Management 548
Personnel 611, 612
Real Estate 609, 610

CLASSIFIED ADVERTISEMENTS

ARDIOLOGIST/INTERNIST—Board rtified in both specialties. Seeks posi-on solo, group or hospital based. Write ox No. 90, JMSNJ.

TERNIST—Board eligible, general in-rnist with extensive emergency room perience. Seeking group practice of ternal medicine or emergency room sition. Northern NJ area. Available. ll 212-645-4616. Steven Wolinsky, MD. rriculum vitae and references avail-le upon request.

EDIATRICIAN—Seeks part time posi-n. Pediatric clinic or office. Middle-ed, board certified. Planning to seek ivate practice. Prefer Monmouth or ean County. Willing to work nights d weekends. Write Box No. 73, JMSNJ.

EEDED PHYSICIANS—For successful ll known walk-in medical office center. ntral NJ. Full and part time, skilled rsonable American-trained MDs. Send / to E. V. McGinley, MD, 1005 N. Wash-gton Avenue, Green Brook, NJ 08812. 1-968-8900.

RACTICE FOR SALE—Twenty-year-d, solo, general practice in South-Cen-al NJ. 20 minutes from Philadelphia d 1½ hours from NYC. Busy, efficient, gh net. Just negotiated a seven year signable lease for a new office in the me building. Lovely suburban area th top-rated school systems. A good ace to live and work. Leaving to go sail-g. Write Box No. 86, JMSNJ.

RACTICE—Solo Family Practice avail-le in county seat, South Jersey. Office home. Hospital across town. Write Box . 85, JMSNJ.

RACTICE—Active Family and Indus-al Practice in Bergen County available on. Excellent opportunity. Write Box . 88, JMSNJ.

FOR SALE—House/Office. Fully equipped medical office, well established practice; general and internal medicine. Near hospital, Central NJ. Write Box No. 89, JMSNJ.

FOR SALE—X-ray, Fisher 300 MS, very little use, reasonable. Call 201-627-2544.

FOR SALE—ECG portable COMPUT-EK, like new, with 2 boxes ECG roll paper, $900. Telephone days 201-750-8474 or nights 201-647-3793.

FOR SALE—Tax-sheltered, income producing opportunity. Cash in on high "drinking & driving" awareness with commercial quality coin-operated, alcohol breath analyzers. May be placed in bars, clubs, restaurants, etc. Call 609-235-4358.

FOR SALE or RENT—Kearny. Fully equipped and furnished medical office building including patients' records. Corner location on main street. Call after 8 p.m. 201-746-1709.

FOR SALE or RENT—Central Jersey. For immediate occupancy new, modern, energy efficient rental 500 to 2,000 square feet available. 31,000 residents within three mile radius. Close to Philadelphia, Atlantic City, in Central Jersey shore area. Internists and specialties needed. Ideal for main/satellite office. Call 201-350-1008.

FOR RENT—Professional office for rent. Approximately 710 square feet. Near Dover General Hospital. Near Routes 80 and 46. Morris County, New Jersey. Telephone 201-366-2557.

FOR RENT—Professional office space for rent. Millburn prestigious building, 775 square feet. On-site parking, on bus route. Call 201-731-1900.

FOR LEASE—Attractive, modern medical building, Morris Avenue, Union Center, Union, NJ. Office for lease. 750 square feet, large, private adjoining parking lot, 1st floor, no steps ... will build to suit. Phone 201-688-2480.

OFFICE TO SUBLET—Medical office to sublet in professional building in Deptford (Woodbury) area. 609-853-8720.

OFFICE SPACE—For rent, medical office fully equipped and furnished. 1,300 square feet. Atlantic City. Call 609-822-0270.

OFFICE SPACE TO SHARE NEEDED—Board certified pediatrician desires office space in Edison/Metuchen to share. Write to Box No. 87, JMSNJ.

OFFICE SPACE TO SHARE—Livingston. 349 E. Northfield Road. Near St. Barnabas. Fully furnished. All utilities included. Near public transportation. Available immediately. 201-992-1124.

OFFICE FOR SHARE or RENT—At 2 locations in Hudson County, furnished, parking, close to hospitals, and transportation. All utilities included. 201-864-7172.

OFFICE TO SHARE—Bergenfield. Centrally located professional building. Parking, furnished, 900 square feet. $450. Five minutes from hospitals. Summer 1984. Write or call Ronny Meier, MD, 297 S. Washington Ave., Bergenfield, NJ 07621. 201-385-8350.

OFFICE FOR SHARE or RENT—New Brunswick, Highland Park area. Furnished, 700 square feet. Ample parking. Close to the hospital. $500/month plus utilities, for rent. For share, $300/month including utilities. Call 201-572-5050 or 572-7553.

TE INFORMATION FOR MEMBERS: $5.00 per insertion up to 25 words; 10 cents each additional word. Payable in advance. **ORD COUNT:** Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of mbers, hyphenated words. Count name and address as five words, telephone number as one word, and "Write Box No. 000, JMSNJ" as six words. **COPY DEADLINE:** Fifth of preceding month.

MEDICAL PRACTICE SALES AND APPRAISALS

We specialize in the valuation and selling of medical practices. If interested in buying or selling a medical practice, contact our Brokerage Division at:

Health Care Personnel Consulting, Inc.
403 GSB Building
1 Belmont Avenue
Bala Cynwyd, PA 19004
215-667-8630

Doctor: Relief is Here!

Dynamic professional, Midwest experience, with nine years in Health Care Industry, available for **MANAGEMENT** position with responsibility for Medical Group in Tri-State area. Expertise in Cost Containment, Data Processing, Marketing and Health Care Legislation.

Can relieve you of your administrative problems, immediately.

Call: **201-934-9786**

Associate Medical Director

South Jersey office, major national firm, seeks a sociate Medical Director; part-time initially; ever a full-time career opportunity with compet v salary/benefits; requires sound professional b k ground; experience, or substantial interest in utiliza c control/peer review/medical administration. Re e strictly confidential. Reply to:

Box No. 80
JMSNJ
2 Princess Road
Lawrenceville, NJ 08648

INTERNIST, FAMILY PRACTICE FREESTANDING E.R. PHYSICIAN

Multispecialty practice based in Philadelphia and Cherry Hill, N.J. Great opportunity with financial security. Staff affiliation with University Hospital. Not an HMO. Main office in Cherry Hill, N.J. 10 minutes away from Philadelphia.

CHERRY HILL HEALTH CARE ASSOCIATES, P.A.
7740 Maple Avenue
Pennsauken, NJ 08109 (609) 488-3505

OUTSTANDING PRACTICE OPPORTUNITIES.

Modern, well-equipped hospital in Western Pe sylvania will assist setting up private practices in THOPEDIC SURGERY, FAMILY PRACTICE, OPHT MOLOGY, and MEDICAL ONCOLOGY. Requires Bo Eligible or Certified physicians in each specialty.

Attractive suburban, semi-rural location, excellen come guarantee. Strong demand for new doctors sures large client base. For more information con Carol Kennedy, 1-800-441-0996, c/o Garofolo, Cu & Co., Physician Recruitment Division, 326 W. I caster Ave., Ardmore, PA 19003.

Need A Temporary Physician?

CompHealth treats your practice as if it were our own during: vacations, CMEs, recruiting, clinic start-up or other absences.

Want Free Time While You Practice Medicine?

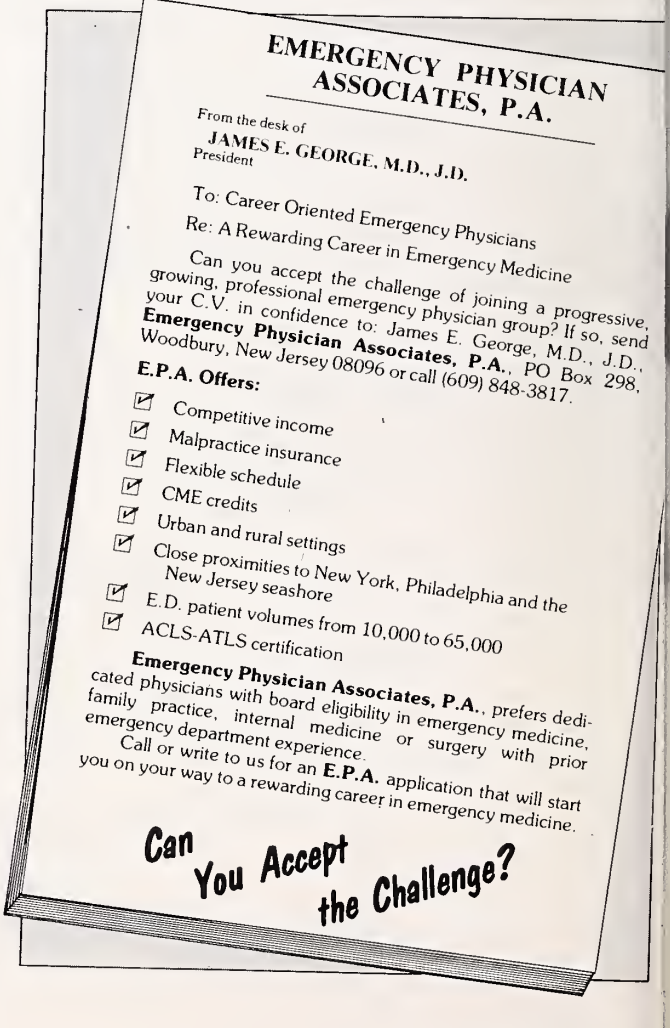
Join CompHealth's Locum Tenens Physician Group.

★

For further information about temporary coverage or locum tenens practice opportunities, call:

CompHealth
A Physician Group

WILSON ROSS, Regional Administrator
244 East Hanover St.
Trenton, NJ 08608
Telephone: 609-392-1111



THE JOURNAL OF THE MEDICAL SOCIETY OF

NEW JERSEY

AUGUST 1984

LIBRARY
U.C. SAN FRANCISCO
SEP 7 1984



THE GERIATRIC IMPERATIVE

The Library
Acquisitions Division
Univ. of Calif., San Francisco
San Francisco, Calif. 94143 S

Send this coupon for no-obligation information of the savings under the Medical Society of New Jersey Endorsed Insurance Plans

Check this list against your coverages . . . .

- ☐ $5000 Monthly Guaranteed Convertible Accident and Health
- ☐ $10,000 Monthly Practice Overhead Expense
- ☐ $1,250,000 Term Life Insurance
- ☐ $500 Deductible COMPREHENSIVE MILLION-DOLLAR MAJOR MEDICAL PLAN—No other coverage needed—Issuable to Age 69
- ☐ $15,000 Deductible MILLION-DOLLAR UMBRELLA MAJOR MEDICAL PLAN for holders of Blue Cross and other Major Medical Plans—Issuable to Age 69
- ☐ $100-a-day Hospital Income Policy
- ☐ $200,000 High Limit Accident Plan
- ☐ Keogh and Corporate Plan NOW! $15,000 KEOGH

E. & W. Blanksteen Agency, Inc.

E. & W. Blanksteen
75 Montgomery St.,
Jersey City, N.J. 07302
(201) 333-4340
or 1-800-BLANKAG

Name: _____

Address: _____

_____

Tel. No. _____

Best Time To Call _____

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

presents

300 YEARS OF MEDICINE IN NEW JERSEY

September 1984

We are celebrating the history of medicine in New Jersey. This special issue illuminates the beginnings of our health care system and the growth of medical care: essays highlight those talented individuals who devoted themselves to this system, and commentaries present the development of specialized care in associated fields of medicine. Plus a special photography section highlighting three statewide exhibits.

Copies of this issue are available by sending $5.00 (check or money order) to MSNJ, Two Princess Road, Lawrenceville, NJ 08648. All MSNJ members will receive one copy of this issue.

Name_____

Address_____

_____

Enclose a $5.00 check or money order for each copy.

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

Officers and Trustees

PRESIDENT AND CHAIRMAN OF THE BOARD
Frank Y. Watson, M.D. (Essex) ..... Glen Ridge
PRESIDENT-ELECT
Ralph J. Fioretti, M.D. (Bergen) ..... Rochelle Park
FIRST VICE-PRESIDENT
Edward A. Schauer, M.D. (Monmouth) ..... Farmingdale
SECOND VICE-PRESIDENT
Harry M. Carnes, M.D. (Camden) ..... Audubon
IMMEDIATE PAST-PRESIDENT
Alexander D. Kovacs, M.D. (Union) ..... Scotch Plains
SECRETARY
Arthur Bernstein, M.D. (Essex) ..... South Orange
TREASURER
Paul J. Hirsch, M.D. (Somerset) ..... Bridgewater

Trustees

Joel S. Cherashore, M.D. (1986) (Essex) ..... Nutley
Douglas M. Costabile, M.D. (1987) (Union) ..... Murray Hill
Palma E. Formica, M.D. (1987)
(Middlesex) ..... New Brunswick
Harry W. Fullerton, Jr., M.D. (1985)
(Salem) ..... Carney's Point
Frank Gingerelli, M.D. (1986) (Bergen) ..... Hackensack
Michael M. Heeg, M.D. (1987) (Mercer) ..... Trenton
Louis L. Keeler, M.D. (1985) (Camden) ..... Collingswood
John P. Kengeter, M.D. (1987) (Ocean) ..... Toms River
Edwin W. Messey, M.D. (1985) (Burlington) ..... Willingboro
Myles C. Morrison, Jr., M.D. (1985) (Morris) .... Morristown
John J. Pastore, M.D. (1986) (Cumberland) ..... Vineland
Carl Restivo, Jr., M.D. (1987) (Hudson) ..... Jersey City
Bernard Robins, M.D. (1987) (Essex) ..... Springfield
Gerald H. Rozan, M.D. (1987) (Passaic) ..... Wayne

Councilors

FIRST DISTRICT
(Essex, Morris, Union, and Warren Counties)
Edward M. Coe, M.D. (1987) ..... Cranford
SECOND DISTRICT
(Bergen, Hudson, Passaic, and Sussex Counties)
Robert A. Weinstein, M.D. (1986) ..... Newton
THIRD DISTRICT
(Hunterdon, Mercer, Middlesex, and Somerset Counties)
Louis G. Fares, M.D. (1985) ..... Trenton
FOURTH DISTRICT
(Burlington, Camden, Monmouth, and Ocean Counties)
Frederick W. Durham, M.D. (1987) ..... Haddonfield
FIFTH DISTRICT
(Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties)
Paul H. Steel, M.D. (1986) ..... Atlantic City

AMA Delegates

William J. D'Elia, M.D., *Chairman* (1985) ..... Spring Lake
Alfred A. Alessi, M.D. (1986) ..... Hackensack
Frederick W. Durham, M.D. (1986) ..... Haddonfield
Palma E. Formica, M.D. (1986) ..... New Brunswick
Karl T. Franzoni, M.D. (1986) ..... Trenton
John S. Madara, M.D. (1986) ..... Salem
Henry J. Mineur, M.D. (1986) ..... Cranford
Myles C. Morrison, Jr., M.D. (1985) ..... Morristown
Howard D. Slobodien, M.D. (1985) ..... Metuchen

AMA Trustee

James S. Todd, M.D. (Ridgewood) ..... Bergen

August 1984

Publication Committee

Paul J. Hirsch, M.D., *Chairman*
Dirck L. Brendlinger, M.D.
Frederick B. Cohen, M.D.
A. Olusegun Fayemi, M.D.
Robert M. MacMillan, M.D.
Leon G. Smith, M.D.
La Verne Fioretti

Editor

Arthur Krosnick, M.D.

Managing Editor

Geraldine R. Hutner

Assistant Managing Editor

Dorothy J. Griffith

Advertising Manager

E. Elizabeth Cookson

Executive Director

Vincent A. Maressa

Executive Director Emeritus

Richard I. Nevin

Editorial Board

Jerome Abrams, M.D. (Obstet/Gynecol)
Joseph Alpert, M.D. (Vasc Surg)
Harold Arlen, M.D. (Otolaryngol)
Alfonse Cinotti, M.D. (Ophthalmol)
Robert Dodelson, M.D. (Nephrol)
Norman H. Ertel, M.D. (Int Med/Endocrinol)
Daniel P. Greenfield, M.D. (Psychiat)
Christine E. Haycock, M.D. (Sports Med)
Monroe S. Karetzky, M.D. (Pulmon Med)
Avrum L. Katcher, M.D. (Pediatr)
Stanley C. Leonberg, Jr., M.D. (Neurol)
Joel D. Levinson, M.D. (Gastroenterol)
Joseph A. Lieberman, III, M.D. (Fam Med)
Henry R. Liss, M.D. (Neurosurg)
Geobel A. Marin, M.D. (Int Med/Gastroenterol)
Donald G. McKaba, M.D. (Allergy)
Robby Meijer, M.D. (Plas Surg)
Frank T. Padberg, Jr., M.D. (Surg)
Christopher A. Papa, M.D. (Dermatol)
Norman Riegel, M.D. (Book Review)
Edwin L. Rothfield, M.D. (Cardiol)
Benjamin F. Rush, Jr., M.D. (Surg)
Morris H. Saffron, M.D. (Med His)
Mark M. Singer, M.D. (Int Med/Endocrinol)
Sheldon D. Solomon, M.D. (Rheum)
Lloyd N. Spindell, M.D. (Radiol)
A. Arthur Sugerman, M.D. (Psychiat)
Stephen F. Wang, M.D. (Pediatr)
Edwin S. Wilson, M.D. (Radiol)
Louis S. Zeiger, M.D. (Nucl Med)
Robert B. Zufall, M.D. (Urol)

The Journal of the Medical Society of New Jersey (ISSN-0025-7524) is published monthly (since 1904) except semimonthly in July (13 issues), under direction of the Committee on Publication, by the Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648. Printed in East Stroudsburg, PA, by the Hughes Printing Co. Whole number of issues 965. Member's subscription ($10) is included in Society dues. Rates for nonmembers $20; outside USA add $7.50 for postage. Single copies, $2. Address communications to *The Journal* MSNJ, Two Princess Road, Lawrenceville, NJ 08648, (609) 896-1766. Second-class postage paid at Trenton, NJ, and additional entry office.

Copyright 1984 by the Medical Society of New Jersey.



The Easy Alternative...

Lease the car of your choice from us. You choose the model, color and options ... we do the rest! Our leasing program can be custom-tailored to include insurance, if you desire. We feature personalized service and the extra attention to detail you're looking for.

Call us today at (201) 257-2300 or (212) 964-0037 to lease YOUR car ... the convenient, easy way.

RUTGERS LEASING inc.

6 Connerty Court • East Brunswick, NJ 08816

Note: If you're new to medical practice in N.J. . . .

You don't have to buy commercial malpractice insurance

JAMES S. TODD, M.D., *Chairman/Board of Directors, Medical Inter-Insurance Exchange of New Jersey*

If you made your decision to establish yourself in New Jersey, you no doubt heard horror stories about our professional liability insurance problems. The legal risks we assume in this business have grown so far out of proportion that many commercial underwriters have been simply unable to cope, resulting in abrupt and often untimely suspension of coverage.

As a new practitioner in this State, either relocating or just beginning your professional career, you have an alternative to commercial insurance. The Medical Inter-Insurance Exchange provides an opportunity to build your new practice on the most secure footing possible with long-term peace of mind.

Founded in 1977 at the peak of the "premium crisis," the Exchange is a wholly doctor-owned cooperative organization through which we insure *ourselves* for our own sake. Membership has grown to two-thirds of all practicing physicians and surgeons in the state. Because we're in it for security — *not for profit* — we can provide for ourselves the absolute best available insurance product for the money. Every dollar we take in goes toward protection (no sales commissions) and every dollar left over is returned to us — in cash.

You owe it to yourself to know your options and the practicalities of each. We're here to help you sort them all out. Call and talk directly to our Vice President and Director of Policyholder Services, Bill Reilly, **TOLL FREE (in N.J.) 800-257-6288** or (609) 896-2404 from other areas. We look forward to hearing from you.

A professional service message from the **Medical Inter-Insurance Exchange** of N.J.
Two Princess Road, Lawrenceville NJ 08648
(609) 896-2404

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

AUGUST 19

FEATURES

619 Membership Newsletter
623 Physician Legal Bulletin
629 Professional Liability Commentary
631 Editorials
635 Hospital Governing Boards

CONTRIBUTIONS

637 Geriatric Imperative: Should Community Hospitals Have Geriatric Units?
M.A. Nevins, M.D., Woodcliff Lake

643 Geriatric Imperative: The Interface Between the Acute Hospital and Long-Term Care
W.J. Kane, M.D., and D.C. Kennie, M.G., CH.B., Mount Holly

647 Geriatric Imperative: An Opportunity for Change
R.B. Milch, Passaic

651 Geriatric Imperative: Geriatric Assessment Programs
L.Z. Rubenstein, M.D., Sepulveda, CA

655 Geriatric Imperative: The Acutely Ill Elderly
L.A. Joel, Ed.D., Newark

661 Geriatric Imperative: Summary Statement of ACP Study Group
M.A. Nevins, M.D., S. Alexander, M.D., F. Chinard, M.D., E. Harris, M.D., M. Wallen, M.D., Woodcliff Lake

663 Pharmacological Basis of Therapeutics: Gossypol, An Oral Male Contraceptive?
S.M. Penningroth, Ph.D., Piscataway

667 The Impaired Physicians Program: Another Kind of Impairment
E.D. Reading, M.Div., Lawrenceville

669 Your Congressman Speaks: The Cost of Health Care
Congressman Jim Courter

DOCTORS' NOTEBOOK

672 UMDNJ Notes, *Stanley S. Bergen, Jr., M.D.*
673 MSNJ Auxiliary, *Grace Gellman*
673 New Members
674 Physicians Seeking Location in New Jersey

MSNJ DEPARTMENTS

677 CME Calendar
681 Letters to the Editor
683 Book Reviews
685 Obituaries
687 Information for Authors

On The Cover: The Serenata Quartet is a fine example of the challenge and opportunity of the new geriatric imperative. Members of this excellent string quartet include: Beverly Palmer, violin (61); Stuart Jolly, violin (65); David Rounds, cello (77); and Kay Knudsen, viola (78). Photo by Joe Dixon.

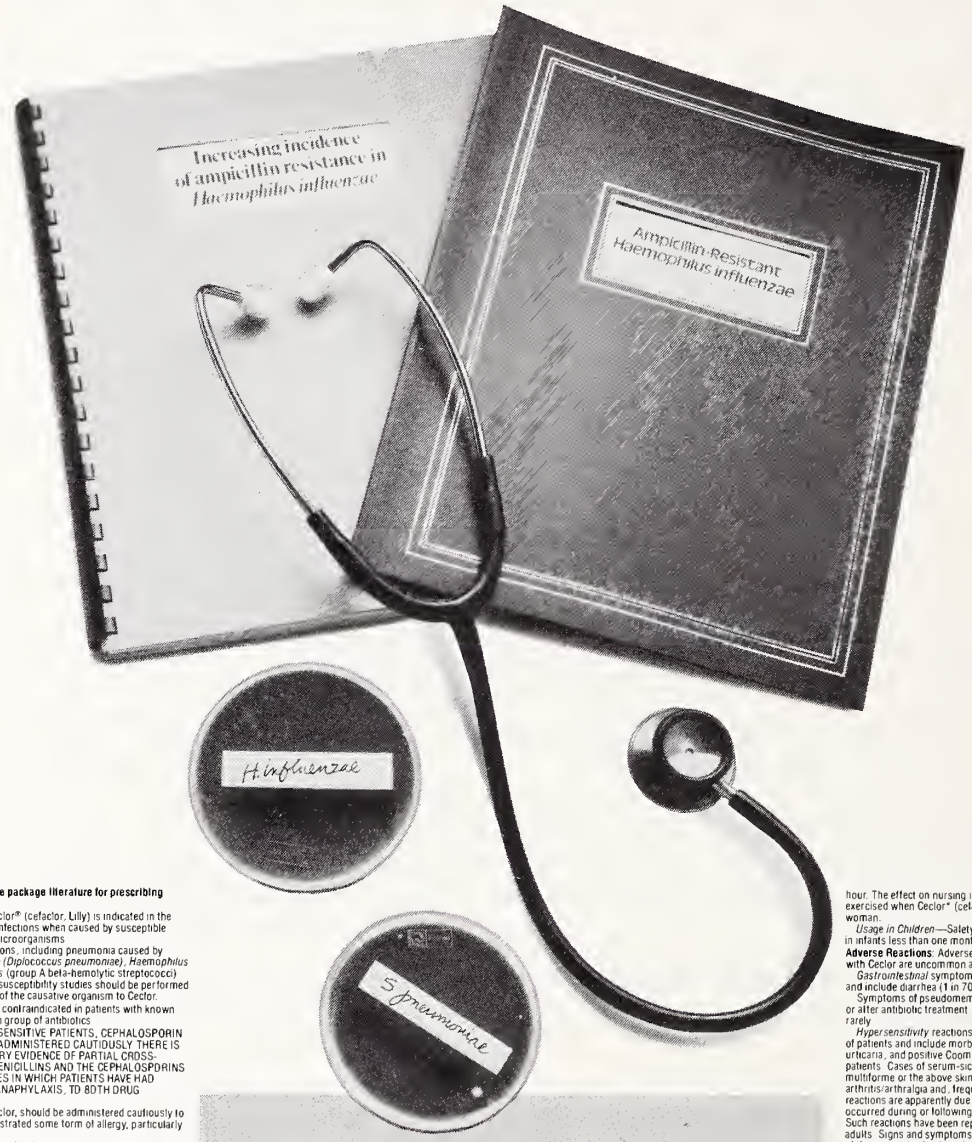


to make sure your getting the best cellular mobile telephone, read the fine print. If it doesn't say GE STAR by General Electric you're not getting a cellular phone where you can take the unit with you when leaving your car to prevent theft, nor are you getting a unit so small it can fit in any car or model.

If you can read this fine print and call 609-655-2225 and advance order a GE STAR cellular mobile telephone you will receive a free GE 25″ color TV or GE Video camera.

future communications—usa, inc.
p.o. box 1062
hightstown, n.j. 08520

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor
Pulvules®, 250 and 500 mg

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.19, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGDT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., *8*:91, 1975
2. Antimicrob. Agents Chemother., *11*:470, 1977.
3. Antimicrob. Agents Chemother., *13*:584, 1978
4. Antimicrob. Agents Chemother., *12*:490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II:880. Washington, D.C.: American Society for Microbiology, 1978
6. Antimicrob. Agents Chemother., *13*:861, 1978
7. Data on file, Eli Lilly and Company
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979

© 1982, ELI LILLY AND COMPANY

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

300035

MEMBERSHIP NEWSLETTER

MSNJ

THE MEDICAL SOCIETY OF NEW JERSEY VOLUME 14

ORKSHOP ON CME NEEDS ASSESSMENT AND TE SURVEYS

On September 19, 1984, between the hours of 9:00 .. and 4:00 P.M., The Academy of Medicine of New rsey and the Medical Society of New Jersey jointly ll sponsor a workshop at the MSNJ Headquarters, o Princess Road, Lawrenceville.

This program will feature noted experts in the CME ld discussing practical approaches to needs sessment and site surveys governed by ACCME es- ntials.

Those physicians acting in DME capacities, hospital d specialty society program chairmen, program or ME committee members as well as nonphysician ME support staff should attend.

Mark your calendar now for this important meeting. gistration materials have been sent. For additional formation or clarification, contact the Executive Of- es at (609) 896-1717.

MA TO PRODUCE FEE FREEZE POSTER

A poster that shows physician support for a one-year e freeze appeared in the May 25 edition of *American edical News*. It may be torn out and displayed in ception areas. Here is the wording of the poster: "I ve voluntarily frozen my fees for one year beginning bruary 1984. I am supporting the policy of the nerican Medical Association and other medical so- eties to do my fair share in holding down the cost medical care. If it is difficult for you to pay my fees cause you are uninsured, unemployed, or on a fixed come, let's talk about it."

A limited supply of extra posters is available from the epartment of Consulting Services. Contact Heidi ough, communications coordinator, Department of onsulting Services, AMA, (312) 645-4413.

ABY DOE REGULATIONS INVALIDATED

A U.S. court struck down the "Baby Doe" regulations, ling in favor of the AMA and other medical organiza- ons in the lawsuit they brought last March 12.

In response to the favorable decision, John J. Coury, .D., chairman of AMA's board of trustees, and Frank Jirka, M.D., AMA president, issued the following joint statement: "The American Medical Association is elated with the ruling of the United States district court for the southern district of New York invalidating the final Baby Doe. This ruling affirms that the federal government does not belong in cases involving the medical treatment of severely handicapped newborns. The AMA believes the care of these newborns should be the responsibility of the parents, in consultation with their physicans and other professionals on the medical treatment team."

FOREIGN-TRAINED PHYSICIANS

Foreign-trained physicians account for 21.2 percent of the physician population in the United States, according to the AMA Division of Survey and Data Resources. The 7,591 Canadian physicians, who were counted in a separate category, represented 1.5 percent of the physicians in this country. India trains the largest number of foreign medical graduates now practicing in the United States (17,031 or 16 percent of this country's 106,586 FMGs) followed by the Philippines (13,323 or 12.5 percent), Mexico (6,793 or 6.4 percent), and South Africa (3,588 or 3.4 percent).

REQUIREMENTS FOR ISSUING A PRESCRIPTION: 13:35-6.6

(a) Physicians and podiatrists shall provide the following information on all prescriptions:

1. Full name, age, and address of patient;
2. Prescriber's full name, address, telephone number, and proper degree designation as appears on prescriber's license;
3. Prescriber's BNDD number when required for the dispensing of controlled substances. (Controlled Substance Act of 1970);
4. Date of prescription;
5. Name, strength, and quantities of drug or drugs to be dispensed;
6. Adequate instruction for the patient (P.R.N. or "as directed" alone is not sufficient);
7. Number of refills permitted or time limit for refills or both;
8. Signature of prescriber;

9. When preprinted prescription blanks are not available the full name of the prescriber must be printed or stamped in block letters under the signature of prescriber;

10. In no instance shall a physician or podiatrist sign a blank prescription form which does not conform with the above standards.

(b) Failure to comply with this ruling will subject the physician to disciplinary sanction in accordance with the Medical Practice Act.

LEGALIZE USE OF HEROIN

Legislation to establish a four-year program under which injectable heroin would be made available for terminally ill cancer patients suffering from intractable pain will be considered by the House of Representatives. The AMA opposes H.R. 5290. They believe that the bill would establish an inappropriate precedent by pre-empting the consumer-protection features of the Food and Drug Administration's (FDA) new drug approval process. Moreover, there is no evidence that making heroin available for the relief of pain from cancer would provide an additional benefit to patients since equally effective medications—such as morphine and dilaudid HP—already are available. We also are concerned that passage of H.R. 5290 could result in an increase in illicit drug diversion.

MINI-RESIDENCY IN PRESCRIBING CONTROLLED DANGEROUS SUBSTANCES

The Mini-Residency in Prescribing Controlled Dangerous Substances is being offered November 13, 1984, at the University of Medicine and Dentistry—Rutgers Medical School, Medical Education Building.

The program is being offered to upgrade physician knowledge of controlled dangerous substances. There has been indications that some physicians have encountered difficulties with the State Board of Medical Examiners resulting from irregularities in controlled dangerous substance prescribing.

The didactic portion will be scheduled for a full 3 days, 9:00 A.M. to 5:00 P.M., each week for four consecutive weeks—a total of 12 days. A 42-hour week clinical rotation follows the didactic portion.

The Mini-Residency is an effort to assist physicians who desire to obtain additional training in the use of controlled dangerous substances either for professional upgrading or licensure requirements.

The proposed date for the next Mini-Residency is November 13, 1984, in New Brunswick. The exact dates for the didactic portion are Tuesday, November 13, 1984, Wednesday, November 14, 1984, Thursday, November 15, 1984, Monday, November 19, 1984, Tuesday, November 20, 1984, Wednesday, November 21, 1984, Monday, November 26, 1984, Tuesday, November 27, 1984, Wednesday, November 28, 1984, Monday, December 3, 1984, Tuesday, December 4, 1984, and Thursday, December 6, 1984.

Registration is now open, but limited. The initial enrollment registration of $200 is nonrefundable.

Full payment of the balance of $2100 is due by o vember 5, 1984. Payment installments will be acce in accordance with the following schedule: Octob 1984, October 22, 1984, and November 5, 1984.

No one will be permitted in the course after No ber 6, 1984, unless full payment is rendered.

If you have any questions regarding the cours registration, please call 609-757-4676.

PROSPECTIVE RULE: UTILIZATION OF INSURA BENEFITS

The Division has proposed a rule which will ap in a subsequent issue of the *New Jersey Regist*.

The proposal allows providers to submit claim insurance companies by acting as assignee for Commissioner, New Jersey Department of Human vices. The proposal concerns those situations w the Medicaid patient has third party coverage, o than Medicaid, but the policy holder is not avail to sign the claim form.

AIDS

The New Jersey State Department of Health rece completed pamphlets entitled, "Acquired Immune ficiency Syndrome." The pamphlets published in E lish, Spanish, and French are designed to inform general public regarding AIDS and its symptoms. pamphlets also discuss how to avoid becoming AIDS victim and lists names, addresses, and ph numbers of organizations available for additiona formation.

These free pamphlets may be obtained by writin calling the New Jersey State Department of Hea Communicable Disease Services, Room 702, CN Trenton, NJ 08625, (609) 292-7300, Monday to Fri 8:45 A.M. to 4:45 P.M.

PHYSICIAN'S CONFERENCE

There will be a Women Physicians' Leadership C ference on Saturday, October 27, 1984, at UMD Rutgers Medical School, Medical Education Build New Brunswick. For more information, please MSNJ, Office of Public Relations, 609-896-1766.

PROSPECTIVE RULE: AUTHORIZATION TO RELEASE INFORMATION REGARDING PRESCRIPTIONS

The Division has proposed a rule which will ap in a future issue of the *New Jersey Register.* proposal will authorize prescribing practitioners t lease to the Division, or any law enforcement autho information about prescriptions which have been by PAAD. A statement to this effect already appear the beneficiary's application.

FINI

"Those who bring sunshine to the lives of ot cannot keep it from themselves."

CARE FOR YOUR COUNTRY.



As an Army Reserve physician, you can serve your country and community with just a small investment of your time. You will broaden your professional experience by working on interesting medical projects in your community. Army Reserve service is flexible, so it won't interfere with your practice. You'll work and consult with top physicians during monthly Reserve meetings. You'll also attend funded continuing medical education programs. You will all share the bond of being civic-minded physicians who are also commissioned officers. One important benefit of being an officer is the non-contributory retirement annuity you will get when you retire from the Army Reserve. To find out more, simply call the number below.

CALL COLLECT OR USE THE COUPON AT BOTTOM:

215-443-1703/1705

CPT HARRY SIMPSON
AMEDD Procurement Office
31-D N. York Road
Hatboro, PA 19040

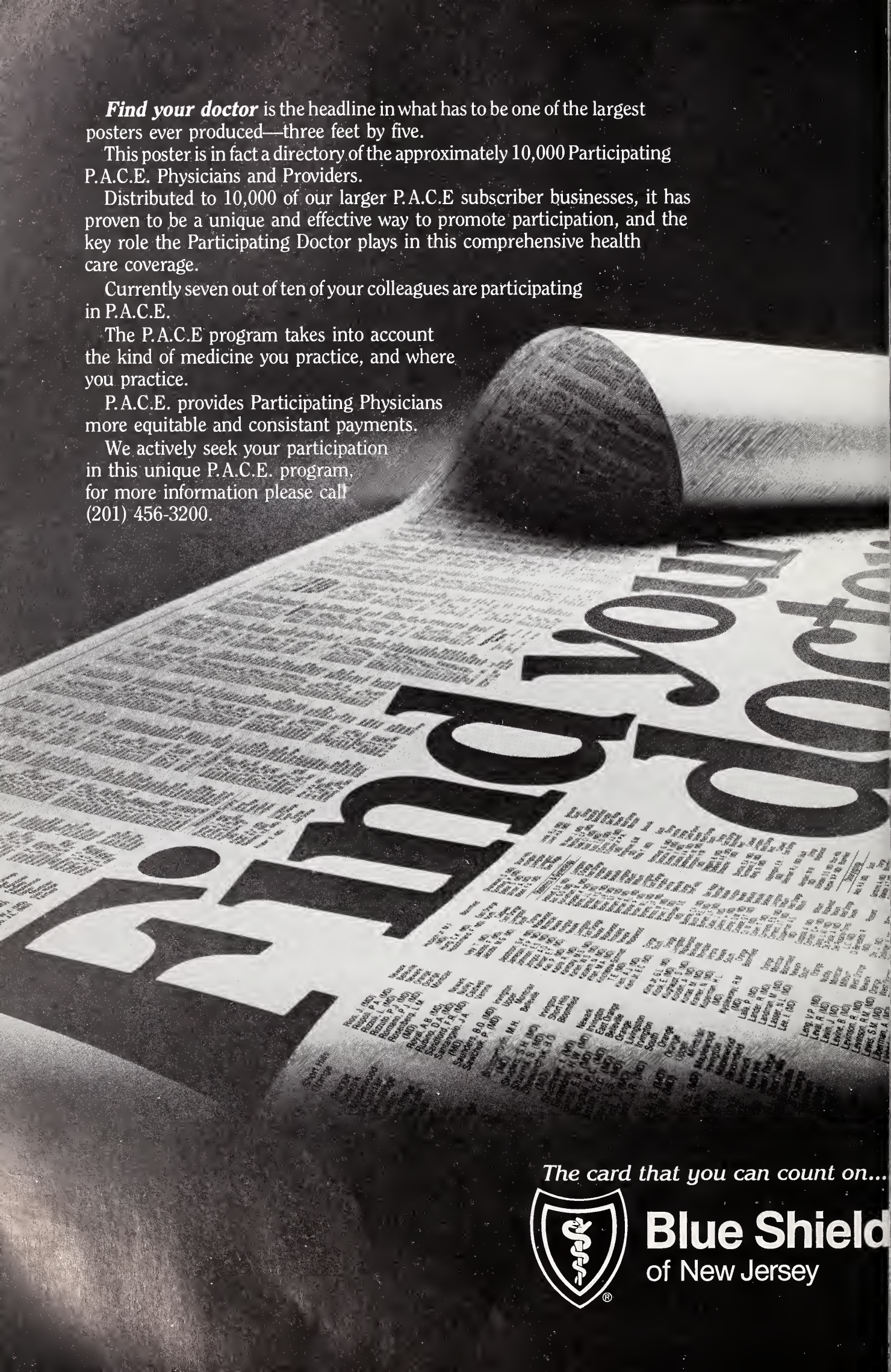
NAME: _____ , MD/DO

SPECIALTY: _____

ADDRESS: _____

TELEPHONE: _____

BEST TIME TO CALL: _____ (AM/PM)



Find your doctor is the headline in what has to be one of the largest posters ever produced—three feet by five.

This poster is in fact a directory of the approximately 10,000 Participating P.A.C.E. Physicians and Providers.

Distributed to 10,000 of our larger P.A.C.E subscriber businesses, it has proven to be a unique and effective way to promote participation, and the key role the Participating Doctor plays in this comprehensive health care coverage.

Currently seven out of ten of your colleagues are participating in P.A.C.E.

The P.A.C.E program takes into account the kind of medicine you practice, and where you practice.

P.A.C.E. provides Participating Physicians more equitable and consistant payments.

We actively seek your participation in this unique P.A.C.E. program, for more information please call (201) 456-3200.

The card that you can count on...

Blue Shield
of New Jersey

PHYSICIAN LEGAL BULLETIN

MSNJ

THE MEDICAL SOCIETY OF NEW JERSEY VOLUME 4

OBSTETRIC AND GYNECOLOGIC MALPRACTICE

JAMES E. GEORGE, M.D., J.D., AND MADELYN S. QUATTRONE, J.D., LAWRENCEVILLE*

A recent survey sponsored by the American College of Obstetrics and Gynecologists (ACOG) reals that about 60 percent of the respondents have en sued more than once, and in New York, 48.8 rcent have been sued three or more times; 49.7 perit of ACOG members' professional liability suits re based on obstetric claims while 41.3 percent were e result of gynecological surgery.

Litigation against obstetricians and gynecologists s had a substantial impact on the specialty. Respontts to the survey said that the threat of malpractice its and the high cost of insurance have caused them raise their fees, practice medicine more defensively, d restrict their practice. A significant number of the ecialists no longer are practicing obstetrics.

Some have speculated that the technological adnces in the specialty have led to increased expectans on the part of patients. When these expectations e not met, dissatisfied patients may resort to litition.

This issue of the *Physician Legal Bulletin* will highht some troublesome areas in the practice of obtrics and gynecology with a view toward recognizing d reducing recurrent problems which trigger litition.

Plaintiff attorneys are rapidly educating themselves th regard to the medical aspects of obstetrics litition. For example, the March 1984 issue of *Trial* magazine featured an article entitled "Obstetric Negligence: An Introduction to a High-Risk Specialty." Physicians likewise may avoid legal pitfalls through knowledge of some of the legal aspects of claims in this area. Many lawsuits involving birth-related injuries stem from allegations such as failure to adequately monitor labor, inappropriate or excessive use of oxytocin, misdiagnosed presentation, failure to respond quickly enough to signs of fetal distress, and failure to perform a timely cesarean section. Obstetric emergencies, whether immediate or imminent, have given rise to a significant amount of litigation when damage to the infant has occurred. A frequently asserted allegation is the failure of the physician to correctly assess high-risk pregnancies and to take timely and appropriate action to reduce the risk of harm to mother and child.

Consider the following account of a recent New Jersey case as reported in 27 ATLA L. Rep. 87, March 1984. At the time of delivery, the mother was post-term at 44 weeks and markedly obese. Despite notification of the onset of labor and his awareness of the high-risk factors, the obstetrician failed to arrive at the hospital for five hours. A certified nurse midwife, and

*From the Department of Professional Liability Control, MSNJ, where Dr. George is Director and Editor of *PLB* and Ms. Quattrone is Assistant Editor of *PLB*. Correspondence may be addressed to A. Ronald Rouse, MSNJ, Two Princess Road, Lawrenceville, NJ 08648.

a labor room nurse with minimal training in obstetrical care, performed the delivery without a physician present. At delivery, the umbilical cord was wrapped three times around the infant's head, causing perinatal asphyxia. Further, the infant suffered renal ischemia, cortical necrosis with azotemia, and neonatal seizures. As a result, the child sustained brain damage with left-sided hemiparesis and learning impairment.

Subsequently, the plaintiffs filed suit against the defendant obstetrician for the failure to attend the delivery, alleging that the absence of an obstetrician deprived plaintiff of the use of an internal fetal heart monitor rather than an external monitor. Plaintiffs also sued the labor room nurse for the failure to detect abnormal decelerations appearing on the fetal heart monitor tape. The case was settled out of court for $482,056, with contributions by the obstetrician and the nurse.

Another common allegation is the failure of the physician to appreciate and appropriately respond to indicators of fetal distress. Standards set by the American College of Obstetricians and Gynecologists with regard to the indications for use of electronic fetal monitoring as well as monitoring by other means when such equipment is not available, may be introduced into evidence as standards of care against which the conduct of the defendant will be measured.

Today, electronic fetal monitoring is the standard in many hospitals and the failure of the physician to order such monitoring may be below the applicable standard of care. Unfortunately, some hospitals regard storing the fetal monitor tracings as burdensome, and routinely destroy the fetal monitoring strips. In many cases the destroyed tracings may deprive the defendant obstetrician of documentary evidence which is supportive of his defense.

Lawsuits arising out of obstetrical claims which allege injury to the child may be labeled "wrongful birth" or "wrongful life." A wrongful birth suit is an action brought by parents who contend that the negligence of the physician resulted in the birth of a "defective" child. Physicians who fail to provide appropriate genetic counseling or who negligently perform a procedure to prevent the birth of a defective child are likely targets of wrongful birth suits. Some wrongful birth suits may be referred to as "wrongful conception" or "wrongful pregnancy" actions. In these cases, the plaintiff alleges that the breach of duty (failed abortion, negligently performed sterilization, or failure to diagnose an existing pregnancy) resulted in the birth of a healthy, normal child.

In the case of *P. V. Portadin*, 179 N.J. Super 465, the Superior Court, Appellate Division, permitted the plaintiffs to bring wrongful birth action. Mrs. P. alleged that she consented to a tubal ligation but that the physician willfully and negligently performed a fallopian rings procedure instead. Despite the procedure Mrs. P. gave birth to a normal child.

The court did not allow the plaintiffs to recover any expenses for raising their normal child but did allow Mrs. P. to recover for "the pain and suffering accompanying her pregnancy and delivery and for the wages lost during that period." Her husband could recover "for loss of consortium and for the medical expenses incurred which are attributable to the pregnancy and delivery."

Damages sought in wrongful birth cases may include expenses related to the unplanned pregnancy and birth, pain and suffering, spousal loss of consortium, and lost wages. The parents of damaged children also are likely to seek damages to compensate them for the cost of past, present, and future medical and rehabilitative care for the child. Parents also may recover for the emotional damages they have sustained upon their realization that their child suffers from a congenital defect or deformity. Whether a successful plaintiff can recover all of these damages depends on the specific facts and circumstances of the case.

Lawsuits alleging wrongful birth may include a claim by the parents or legal guardian on behalf of the child for "wrongful life." A wrongful life action is the damaged child's equivalent of the parents' wrongful birth action. The claim alleges that, but for the physician's negligence, the child would not have been born to experience the pain and suffering attributable to the deformity and such nonlife would have been better.

Unlike wrongful birth actions, wrongful life actions have been received with little favor by the courts. Such suits have been rejected in New Jersey and a number of other states. Courts refusing to recognize wrongful life as a legal cause of action have emphasized that social policy that life, with or without major handicaps, is more precious than nonlife.

Most courts have found it impossible to calculate the damages sought in wrongful life cases. The remedy afforded a plaintiff in the civil law is intended to be remedial or compensatory in order to place the plaintiff in the position he would have been in had he not been injured by the defendant in the first place. Therefore, most courts have found it impossible to calculate damages based on the comparison between life in an impaired condition and the state of nonexistence. Courts traditionally have been unwilling to place a price on nonlife.

Not all courts have found damage in wrongful life actions impossible to calculate. The Supreme Courts of California and Washington and a Superior Court in Arizona have upheld wrongful life claims and allowed recovery for the extraordinary expenses for medical care and special training required by the defective child.

A number of wrongful birth cases have been predicated upon the alleged failure to provide adequate genetic counseling and prenatal testing. Genetic counseling, genetic screening, and amniocentesis are important new areas of liability for obstetricians and gynecologists. A physician may be liable for failing to refer a patient to a qualified genetic counselor, failing to diagnose correctly a genetic condition that is later manifested in the patient's child, or for failing to inform a patient of the consequence of being a carrier of a genetic defect.

Two important New Jersey cases in this area involved failure to advise a woman over age 35 of the risk of Down's syndrome and failure to inform parents that they were carriers of the genetically transferable disease, cystic fibrosis.

In the latter case, 87 N.J. 53 (1981), the Supreme Court of New Jersey held that physicians may be

le for the past, present, and future medical ex-
ses of a defective child which are attributable to his
ase. In that case, the plaintiffs alleged that the phy-
ans had failed to timely diagnose cystic fibrosis in
r first-born child. As a result, the plaintiffs, un-
re that they were carriers of a genetically trans-
ble disease, had a second child. The second child
was afflicted with cystic fibrosis. The court found
t the physicians could be held liable for the medical
enses of both children. The court held that the
sicians had a duty to the first child and a separate
y to the parents to advise them that their first child
ered from cystic fibrosis and to inform them of the
s of conceiving a second child. The court also held
t it was foreseeable that a second child could suffer
n the disease.

1 1979, the New Jersey Supreme Court held that
sicians could be held liable for failure to inform a
ear-old pregnant woman of the availability of am-
centesis.

hysicians, particularly obstetricians should be fam-
with standards and guidelines regarding genetic
nseling. The Genetic Services Program of the New
sey State Department of Health suggests the follow-
indications for referral for genetic counseling:

- Family history of an inherited or chromosomal disorder, or family clustering of a disorder
- Genetic disorder or congenital anomaly in a family member
- Delayed or abnormal physical and/or mental development
- Mental retardation of unknown etiology
- Specific religious, ethnic, or geographic background in which certain genetic diseases are prevalent
- Drug use or chronic exposure to radiation or industrial chemical, particularly known teratogens or mutagens
- History of two or more spontaneous abortions, stillbirths, and/or early infant deaths
- Infertility
- Consanguineous marriage

hese closely parallel the indicators identified by the
A Council on Scientific Affairs (Genetic Counseling
d Prevention of Birth Defects, *JAMA* 248:221, 1982).
he Genetic Services Program suggests the following
ications for consideration of amniocentesis:

- Maternal age 35 or older
- Paternal age 45 or older
- Previous child with chromosomal abnormality
- Either parent a known carrier of a balanced or unbalanced chromosomal abnormality
- Previous child with a neural tube defect or significant family history of a neural tube defect
- Mother a known or presumed carrier of a serious x-linked recessive disorder
- Both parents carriers for a diagnosable autosomal recessive disorder

s the field of genetic counseling and prenatal
ting grows and develops greater recognition, par-
ularly in the media, the public's expectations ac-
dingly will increase. Failure to obtain appropriate
etic counseling no doubt will result in more law-
ts.

The rise in the rate of cesarean births has received significant coverage in the press. See, for example, the article entitled "Controversy Surrounds the Increasing Number of Cesarean Deliveries," *The Wall Street Journal*, Thursday, January 19, 1984. It has been estimated that one out of every five babies born in the U.S. this year will be delivered by cesarean and in the Northeast the figure may be as high as one in three or two out of five. Improved anesthetic techniques, new antibiotics, technological developments in electronic fetal monitoring, and the age-old dictum of "once a cesarean, always a cesarean" all have been cited as contributing to the increase.

Physicians can best protect themselves by keeping thorough records of prenatal visits.

Obstetricians' fear of malpractice suits also undoubtedly has multiplied the number of cesareans. A patient may sue for the unnecessary performance of a cesarean. On the other hand, a substantial number of obstetrical malpractice cases are based on allegations of failure to do a timely cesarean. The potential damages resulting from failure to do a timely cesarean far outweigh the potential damages for performance of an arguably unnecessary C-section. For example, a New York jury awarded $3,318,000 to a plaintiff whose newborn male infant suffers from mild cerebral palsy as a result of traumatic vaginal delivery (*Trotman v New York Hospital*, N.Y. County Supreme Court, No. 9175/77, June 22, 1983). A resident who examined the plaintiff discovered a breech presentation but did not report it. The child was found to be in a single footling breech presentation when the mother's membranes spontaneously ruptured five hours later. Diagnostic x-ray pelvimetry was not performed. The jury agreed with the plaintiffs that the defendants had improperly managed and delivered the child by vaginal route rather than by cesarean section. (The case was reported in 26 ATLA L. Rep. 472 December 1983.)

Inadequate monitoring and delayed cesarean section were alleged in a suit in California (*Unana v Torrance Memorial Hospital*, Los Angeles Superior Court, No. 22-681, Dec. 1982). The plaintiff was admitted to the hospital in active labor. The patient's chart indicated fetal heart irregularity which was shown by external monitoring an hour after admission. The defendant obstetrician was notified by telephone of late decelerations an hour later. Two hours later "prolonged decelerations" were noted and again reported to the obstetrician by telephone. The defendant obstetrician did not arrive at the hospital until two hours later. A cesarean was performed but the child sustained brain injury resulting in severe mental and motor retardation and spastic quadriparesis. The defendants settled for $1,100,000. (The case was reported in 26 ATLA L. Rep. 186, May 1983.)

Gynecologic surgery resulting in unintentional injury to the bladder, nerves, ureters, urethra, uterus, and bowel comprise a significant percentage of claims

against ob-gyns. Illustrative of allegations with regard to gynecologic surgery are the following accounts of two recent cases reported in the *American Trial Lawyers Association Law Reporter.*

In a Rhode Island case the plaintiff reached a $215,000 settlement for the kidney and brain damage of a 39-year-old woman whose right ureter and left common iliac artery unintentionally were ligated during repair surgery.

A survey by the ACOG reveals that 60 percent of the respondents have been sued more than once.

The patient experienced internal bleeding following a cesarean section performed by defendant obstetrician. The physician reopened and, in an attempt to control the bleeding, ligated the left common iliac artery and the right ureter. The absence of a left femoral pulse was noted upon closing. The patient was extubated and suffered respiratory and cardiac arrest. The physician consulted a cardiovascular surgeon who located and ligated a right internal iliac bleeder and freed the mistakenly ligated artery. Ligation of the right ureter was revealed by a pyelogram several weeks following the surgery, but plaintiff required removal of the right kidney. The patient also suffered transient petit mal seizures for two years following the surgery as a result of cerebral anoxia during the cardiac arrest. (26 ATLA L. Rep. 42, 1983.)

A more common allegation is illustrated in the following account of a recent Florida case which resulted in a $507,000 jury verdict for a 32-year-old woman who suffered urinary tract injury during a hysterectomy.

The patient was admitted to defendant hospital for a hysterectomy performed by defendant obstetrician. While tying off blood vessels during the operation the obstetrician placed sutures near one of plaintiff's ureters. Following surgery plaintiff experienced abdominal pain and was unable to eat or drink, but hospital staff did not undertake exploratory surgery. Surgery performed at another facility revealed that the ureter had been blocked by defendant's sutures, causing urine to seep into the body cavity. Plaintiff and her husband brought suit against the obstetrician and against the hospital, for inadequate supervision of a patient under heavy medication. The jury awarded plaintiffs $500,000 from the obstetrician, including $30,000 for loss of consortium, and $7,000 from the hospital. (26 ATLA L. Rep. 42, 1983.)

Cases alleging failure to diagnose breast cancer and especially failure to timely diagnose breast cancer have and will continue to plague physicians. The proliferation of breast cancer cases may stem in part from the concept that early detection is early cure. The public has come to believe, with a degree of faith akin to religious belief, that routine and early screening for breast cancer, significantly will improve survivability.

As a result of a recent breast cancer case decided by the Supreme Court of New Jersey, 95 N.J. 399, 1984, breast cancer cases may be increasingly difficult to defend. The legal issue in that case focused on th issue of "causation." The case involved the followir scenario. A young woman presented to her physicia with a small painful lump in her right breast. After a examination, the physician told her it was "nothing t worry about." Seven months later, the plaintiff r turned with complaints of continued pain, an increas in the size of the lump, and a "sore" with some bleedir in the area. Culture results proved "negative for infe tion." The patient sought an opinion from anothe physician. The patient underwent a right extensiv mastectomy. A pathologist diagnosed infiltrating du tal carcinoma of the right breast. Subsequently, it wa determined that the cancer had metastasized to th lung, rendering the patient's prognosis for recover poor.

The patient sued the physician alleging failure t diagnose the cancer. She contended that the delay i diagnosis increased the risk of metastasis and conse quently deprived her of a chance of long-term survival

The case ultimately reached the New Jersey Suprem Court. It held that a plaintiff should be permitted t demonstrate, within a reasonable degree of medica probability, that the delay resulting from the defendar physician's failure to render an accurate diagnosis an treatment increased the risk of metastasis and tha such increased risk was a substantial factor in produc ing the condition from which the plaintiff suffers.

The court also held that the plaintiff need not qualif the magnitude of the increased risk. Once the plainti has shown that the defendant's negligent act or omis sion increased the risk of harm to the plaintiff, the jur will be permitted to decide whether or not the in creased risk was a substantial factor in producing th resultant harm. The court also ruled that the plainti would recover damages for mental and emotional in jury resulting from the negligent failure to time diagnose and treat the tumor.

As a result of the decision in this case, it is likel that juries will award larger monetary damages tha they would have in the past for cases such as these

RISK REDUCTION

The Department of Risk Prevention of the Medica Inter-Insurance Exchange of New Jersey recently com piled a statistical analysis of 223 ob/gyn claims i which a total of $15,896,752 was paid. A few of th major categories of losses are presented below.

Eleven claims stemming from allegations of failur to diagnose breast cancer resulted in payment t claimants totalling $1,717,000. Delay in obtaining biopsy or failure to biopsy were common allegations i these cases. Breast cancer cases represent the larges gyn loss. Such cases can have a devastating impac where the plaintiff can demonstrate a diminished lif expectancy.

Five claims alleging failure to diagnose and respon to fetal distress resulted in payments to claimant totalling $2,204,830. Where the infant suffers brai damage, the physician may be held liable for the cos of long-term institutional care.

Thirty-three claims involving alleged improper per formance of procedures such as tubal ligations, hys terectomies, abortions, and assisted deliveries resulte

payments totalling $1,459,602.

Gynecological surgery cases causing injury to the tient resulted in payments of $849,327.

ONCLUSION

Medical malpractice liability is clearly expanding in e area of obstetrics and gynecology. This is partly a sult of legal recognition of new theories of liability d expanded areas for the award of damages.

Physicians who continue to practice in this high- sk specialty can best protect themselves by keeping orough records of prenatal visits and other care ovided. Conclusions should be well documented with pporting reasons.

Where fetal monitoring and other technology is used, the physician should be mindful that hospital personnel may not be as skilled as the physician would wish with regard to the use and interpretation of the data generated. Electronic fetal monitoring should never be a substitute for the exercise of the physician's clinical judgment. Physicians should encourage hospitals to store and make readily retrievable, all tracings of fetal monitors. In some cases the fetal monitor tracings may represent the only documentary evidence of fetal nondistress.

Ob-gyns also should avail themselves of the technical bulletins published by the American College of Obstetricians and Gynecologists. These bulletins have become "must" reading for plaintiffs' attorneys. No less can be expected of the practitioner.

The RCA solution for paperwork headaches.

Introducing the cure to all your administrative headaches. The Medical Management System from RCA. This unique system was designed by a physician for physicians. It handles everything from insurance claims and patient billing to invoice tracking and cash disbursements. It takes the hassle out of time-consuming billing procedures and gives you greater control of the business side of your practice.

You'll feel good about the RCA Medical Management System when you see the price, too. It's affordable. Easy to use. And includes an IBM personal computer, a high-capacity disc storage unit, a printer, and the RCA Medical Management software.

We'll take care of everything — delivery, installation and user training. And the entire system is backed by RCA's one-year, on-site service warranty.

Make an appointment today to see a special demonstration of the RCA Medical Management System. Just call collect **(609) 338-4129** and let RCA help make your practice perfect.

RCA Data Services



The Effects of Malpractice

Effects of Malpractice; Informed Consent; Informal Consultations

Sara C. Charles, M.D., recently had completed a survey of Chicago area physicians who have en sued for medical malpractice. Dr. Charles ran-mly selected 154 Chicago physicians who had suits ed against them between 1977 to 1981.

Some of Dr. Charles' findings as reported in the April sue of the *Medical Liability Monitor* are:

- Most physicians (89.6 percent) felt that the plain-f's suit was unjustified, 44 percent resented efforts insurance and legal counsel to settle the case, and percent felt that settling the case was tantamount admitting guilt.
- More than half (54.5 percent) felt that litigation is rt of practicing medicine today and not an affront one's competence, but 88 percent reported feeling ger—mild to severe—over being sued.
- Almost 70 percent of those surveyed said they kept ore meticulous records after being sued, but 25 per-nt said they recorded less "pertinent" information in cords.
- Most of the physicians (62 percent) said they or-red diagnostic tests for "protection" even when nical judgment assessed these as "unnecessary."
- Some 28 percent of the doctors stopped per-rming certain high-risk procedures while 42 percent opped seeing "certain kinds" of patients.
- Twenty-five or 18.8 percent of the respondents felt "loss of nerve in some clinical situations" and 14 rcent said they felt less self-confidence as a physi-an after being sued.
- More than half of the physicians (56.6 percent) felt that they and their families had suffered as a result of the suit, while 19 percent felt that their medical practice had suffered. One-third or 33.6 percent of the doctors thought about early retirement after being sued.

In surveying physicians for symptoms, Dr. Charles had to rely on self-reports since no personal interviews were carried out. But even on paper, two clusters of symptoms emerged: "Of the 143 physicians who assessed themselves for symptoms, 39 percent admitted to four or five symptoms which suggested a possible major depressive disorder; and another 20 percent acknowledged another group of symptoms, including anger, change in mood, inner tension, frustration, irritability, insomnia, fatigue, and headache. Eleven of the physicians (8 percent) noted the onset of a physical illness during litigation, while 3 physicians had a coronary during the process. Almost 8 percent of the doctors reported aggravation of a previously diagnosed illness. Only 4 percent of the physicians said they had no physical or emotional symptoms associated with the malpractice litigation." (*Medical Liability Monitor*, Vol. 9, No. 4, April 30, 1984)

MORE ON INFORMED CONSENT

As if hospitals don't have a big enough hand in your affairs already, they may soon be checking up on how well you have obtained informed consent. In what could be a significant case, an Illinois doctor and hospital both will stand trial on the charge of failing to inform a patient of the risks of a surgical procedure. In the past, hospitals routinely have been dismissed from such cases, but this time an appeals court okayed a trial. If the case establishes a precedent, hospitals could be forced to ensure that you have truly informed the patient of the risks involved, and not just obtained his signature on a form. (*Medical Economics*, March 19, 1984)

LIABILITY FOR INFORMAL CONSULTATION

When an acquaintance asks a physician about his jogger's knee or tennis elbow at an informal gathering, the physician could be held liable for his opinion.

According to the "Practice Management" in the March issue of *Medical Economics*, "By giving an opinion, even in an informal setting, you could be establishing a physician-patient relationship and assuming responsibility for the person's care. Also, your "curbside" opinion might persuade your questioner not to get a proper diagnosis and treatment. If this led to complications, you could be liable. So when an acquaintance asks you for an informal opinion, it is best to either say you would like to be helpful but cannot diagnose his problem without examining him and doing the necessary tests, or advise him to consult a specialist if the problem is out of your field. (*Medical Economics*, March 19, 1984)

---

*This item from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse who are, respectively, Director of the Department and Director of Special Projects.

FIFTH ANNUAL MEDICOLEGAL SEMINAR

Wednesday, September 12, 1984
8:30 a.m.- 4:00 p.m.

Medical Society of New Jersey Executive Offices
Two Princess Road
Lawrenceville, NJ 08648
presented by

Medical Society of New Jersey
Department of Professional
Liability Control

Medical Inter-Insurance
Exchange of New Jersey
Department of Risk Management

Morning Session

8:30 Registration and Coffee

9:00 Greetings
Frank Y. Watson, M.D., President, MSNJ and James S. Todd, M.D., Chairman of the Board, MIIENJ

9:20 **Opening Remarks**
James E. George, M.D., J.D., Director, Department of Professional Liability Control

9:45 **"The Snitch Bills; Their Impact on Medical Malpractice"**
Vincent A. Maressa, Executive Director, MSNJ

10:15 **"Reporting of Medical Malpractice To State Board of Medical Examiners"**
Floyd J. Donahue, M.D., Member of State Board of Medical Examiners

10:45 **"The New Case Management and Procedures of Malpractice Litigation"**
Honorable Peter Ciolino, Assignment Judge Superior Court, Passaic County

11:15 **Questions and Answers**

Afternoon Session

12:00 Lunch

12:45 **"Medical Malpractice; The View from the Chair"**
James S. Todd, M.D. Chairman, Board of MIIENJ

1:00 **"The Professional Liability World Today; The State of the Industry"**
Peter Sweetland, President, MIIENJ

1:45 **"The Claim Climate in New Jersey; A History and a Look at the Future"**
Joseph DeRoma, Vice-President, Claims, MIIENJ

2:30 **"An Ounce of Prevention; Causes of Suits and Programs Developed To Avoid Them"**
Adam P. Wilczek, Director, Department of Risk Management, MIIENJ

3:15 **Questions and Answers**

APPROVED FOR 5½ CME CATEGORY I CREDITS

REGISTRATION
PLEASE RESPOND NO LATER THAN AUGUST 31, 1984
NO REFUNDS AFTER SEPTEMBER 10, 1984

MSNJ MEMBER OR MIIENJ INSURED	$10.00
NON MSNJ MEMBER OR NOT INSURED WITH MIIENJ	25.00

DETACH AND MAIL TO MSNJ, TWO PRINCESS ROAD, LAWRENCEVILLE, NJ 08648

Enclosed is my check for_____payable to MSNJ

NAME (PLEASE PRINT)_____

ADDRESS_____

PHONE #_____

A CONFIRMATION WILL BE SENT TO YOU ALONG WITH DIRECTIONS TO MSNJ.

EDITORIAL

The Challenge of the Geriatric Imperative

MICHAEL A. NEVINS, M.D.*

Can community hospitals meet the challenge of the geriatric imperative? A workshop sponsored by the New Jersey Chapter of the American College of Physicians studied the question.**

How appropriate it is that since their births at the beginning of the century, the codisciplines of eriatrics and gerontology have taken the equivalent a full human life span before entering into their lden age. The frenetic pace of events during the past ecade attests to an emerging awareness of the mensions of what Anne Somers so eloquently has haracterized as "the geriatric imperative."

Much attention has been focused on organizational nsiderations (e.g. whose speciality is it?) and at deloping and introducing curriculum at all levels of edical education. Whereas teaching hospitals and edical schools have begun to meet the challenge of he new geriatrics," there is little evidence that the ation's smaller community hospitals have been reponding comparably. This is alarming since it is difcult to envision an efficient health delivery system for ie elderly in which community hospitals do not play central role. Indeed, it is at these institutions where ost primary care for seriously ill, older people is rovided. Increasingly, the constituency of community spitals is composed of Medicare patients with beveen one-third and one-half of admissions and total spital days currently being devoted to their care.

In pre-World War II England, Marjorie Warren apreciated that conventional care of the elderly by inteation into general hospital wards, often was antiietical to recovery. As a result, discrete geriatric wards nerged early in Great Britain and later in many other untries in Europe and Canada. For example, in 1981, of Israel's 28 general hospitals had acute geriatric ards designed to care for those patients who are more nctionally impaired than their independent colleagues of similar advanced age. Although it is difficult to extrapolate results from countries which operate under nationalized systems to our needs, it is surprising that relatively little attention has been paid in the United States to how the aged are treated within our acute hospitals. Rather, most current attention is being directed at nursing home care, home care, and methods of keeping patients out of hospitals altogether. Although this is commendable, it is unrealistic to presume that the nation's elderly will not continue to occupy a substantial, if not increased, proportion of acute beds in community hospitals. This particularly is the case in New Jersey which in the United States ranks only after Florida in average age of the population.

If the 1970s represented the renaissance of geriatrics, the 1980s and beyond likely will be a period of challenge and opportunity when implementation of many of the lessons of the past decade will be tested for efficacy, practicality, and cost effectiveness. It has become fashionable to revere "the team" as the geriatrics equivalent of high technology. Whether the team concept can be made to work is a crucial question since internists and family physicians, who have tended to work best as solo virtuosi, would have to be remolded into conductors. Medical and nursing schools now are producing a new generation of young geriatricians who will have a fresh perspective on caring for the elderly. Will community hospitals be prepared to receive them and have programs in place to best utilize their talents?

Our workshop provided an opportunity to address one component of the broad spectrum of issues that comprise the current geriatric agenda. It is quite appropriate that the American College of Physicians should sponsor this study since in its long and distinguished history the College consistently has played a central role in supporting innovation and has provided leadership in matters pertaining to excellence of medical care. It is my hope that, as a result of our deliberations, we will be able to identify those factors which constitute good contemporary practice of hospital geriatrics. The series of articles in this issue highlight the discussions from the workshop.

---

*Dr. Nevins is Governor, New Jersey Chapter, American College of Physicians. Correspondence may be addressed to Dr. Nevins, 595 Chestnut Ridge Road, Woodcliff Lake, NJ 07675.

**The workshop was held on May 5, 1983, at MSNJ headquarters, Lawrenceville, and was sponsored by the New Jersey Chapter of the American College of Physicians.

Eye Health Screening Week

ALFONSE A. CINOTTI, M.D.

Eye Health Screening Week will begin September 17, 1984, in 88 New Jersey hospitals. The program is free and readily available.

For the 28th consecutive year, the Medical Society of New Jersey will conduct an eye health screening program in 88 hospitals during the week of September 17, 1984, with the cooperation of the New Jersey Academy of Ophthalmology and Otolaryngology, the New Jersey Hospital Association, the New Jersey State Department of Health, the New Jersey State Commission for the Blind and Visually Impaired, the National Society to Prevent Blindness-New Jersey, and the Lions Club of New Jersey.

Since this program began, over 250,000 people have been screened. There have been a significant number of positive findings including: glaucoma, cataracts, various types of retinopathy, and eye tumors.

Perhaps the greatest impact in sight conservation has been the finding of 3,000 new cases of glaucoma. Since glaucoma is one of the major causes of preventable blindness, early diagnosis permits sight-saving treatment.

In this screening, tests for two of the earliest signs of glaucoma—increased intraocular pressure and progressive cupping of the optic nerve—are performed.

Although this program is free and effective, only a small percentage of the public has taken advantage of the screening. We believe that the program should be expanded. The MSNJ Conservation of Vision Committee, along with other organizations, reviews the project annually in order to determine ways of increasing participation. The Committee especially is concerned with the program's failure to make a greater impact in the inner cities, where the incidence of glaucoma is high and the loss of vision is greater.

There is no question that the MSNJ Eye Health Screening Program has made valuable contributions by promoting knowledge and understanding of eye diseases and the need for periodic eye examinations.

Every physician can aid in screening for glaucoma by a careful ophthalmoscopic evaluation of the optic disc, especially in those patients who are at greater risk: senior citizens, those with family histories of glaucoma, and the black population.

The normal optic nerve has clear margins, pink color, and a physiological cup, which generally is less than .3 of the diameter of the disc, both vertically and horizontally. The cup in both eyes usually is similar. The examiner should refer patients who have large cups, especially where there is a disparity between the two eyes, where the vertical cup is larger, where notching appears in the rim, where the vessels show marked deviation, or where hemorrhages are seen on the disc. It has been established that changes in the optic disc generally occur before demonstrable visual field changes.

Given the benefits of early diagnosis, we encourage physicians to pay special attention to the optic nerve and to remind their patients of the need for periodic eye examinations. The Eye Screening Program is free and readily available.

BALANCED CALCIUM CHANNEL BLOCKADE!



CARDIZEM®
(diltiazem HCl)

balances potent coronary vasodilation with a low incidence of side effects

ow incidence of side effects
ARDIZEM® (diltiazem HCl) roduces an incidence of adverse actions not greater than that ported with placebo therapy, ius contributing to the patient's nse of well-being.

lizem is indicated in the treatment of angina pectoris due to nary artery spasm and in the management of chronic stable ina (classic effort-associated angina) in patients who cannot rate therapy with beta-blockers and/or nitrates or who remain ptomatic despite adequate doses of these agents.

rences:

rauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy f diltiazem hydrochloride for the treatment of stable angina ectoris: Report of a cooperative clinical trial. Am J Cardiol 9:560-566, 1982.

ool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-nducible chronic stable angina with diltiazem: Effect on treadmill xercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

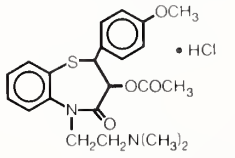
Please see full prescribing information on following page. 2/84

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), asthenia (1.2%), AV block (1.1%). In addition, the foll were reported infrequently (less than 1%) with the orde tion corresponding to the relative frequency of occurr

Cardiovascular:	Flushing, arrhythmia, hypotensi dia, palpitations, congestive h syncope.
Nervous System:	Paresthesia, nervousness, s tremor, insomnia, hallucinations,
Gastrointestinal:	Constipation, dyspepsia, diarrh mild elevations of alkaline phospha SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, ph
Other:	Polyuria, nocturia.

The following additional experiences have been not

A patient with Prinzmetal's angina experiencing vasospastic angina developed periods of transient a asystole approximately five hours after receiving a s dose of CARDIZEM.

The following postmarketing events have been re quently in patients receiving CARDIZEM: erythema mu kopenia; and extreme elevations of alkaline phospha SGPT, LDH, and CPK. However, a definitive cause and ef these events and CARDIZEM therapy is yet to be esta

OVERDOSAGE OR EXAGGERATED RESPO

Overdosage experience with oral diltiazem has b Single oral doses of 300 mg of CARDIZEM have been w by healthy volunteers. In the event of overdosage or response, appropriate supportive measures should be addition to gastric lavage. The following measures may be

Bradycardia	Administer atropine (0.60 to 1.0 is no response to vagal blockade isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. degree AV block should be treat diac pacing.
Cardiac Failure	Administer inotropic agents (isc dopamine, or dobutamine) and diu
Hypotension	Vasopressors (eg, dopamine or l bitartrate).

Actual treatment and dosage should depend on the se clinical situation and the judgment and experience of physician.

The oral/LD_{50}'s in mice and rats range from 415 to and from 560 to 810 mg/kg, respectively. The intravenol these species were 60 and 38 mg/kg, respectively. The dogs is considered to be in excess of 50 mg/kg, while le seen in monkeys at 360 mg/kg. The toxic dose in man is but blood levels in excess of 800 ng/ml have not been with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerosis Coronary Artery Disease or Angina Pectoris at Rest Due Coronary Artery Spasm. Dosage must be adjusted to each needs. Starting with 30 mg four times daily, before me bedtime, dosage should be increased gradually (given doses three or four times daily) at one- to two-day int optimum response is obtained. Although individual pa respond to any dosage level, the average optimum dos appears to be 180 to 240 mg/day. There are no available da ing dosage requirements in patients with impaired renal function. If the drug must be used in such patients, titration carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to a anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may coadministered with short- and long-acting nitrates have been no controlled studies to evaluate the a effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 0088-1771-47) and in Unit Dose Identification Paks of 0088-1771-49). Each green tablet is engraved with MARI side and 1771 engraved on the other. CARDIZEM 60-m tablets are supplied in bottles of 100 (NDC 0088-1772-47) Dose Identification Paks of 100 (NDC 0088-1772-49). Ea tablet is engraved with MARION on one side and 1772 on

Issue

Another patient benefit product from

PHARMACEUTICAL DIVISION
MARION LABORATORIES, INC.
KANSAS CITY, MISSOURI 64137

Government Mandated Peer Review—Delegation to Hospital

VINCENT A. MARESSA, J.D.

The Department of Health and Human Services is required to contract with qualified peer review organizations (PROs) to provide peer review of Medicare and Medicaid claims.

In enacting P.L. 97-248, the Tax Equity and Fiscal Responsibility Act of 1982, Congress inserted a section known as the Peer Review Improvement Act of 1982. By this statute, the Department of Health and Human Services is required to contract with qualified peer review organizations (PROs) to provide peer review of Medicare and Medicaid claims, and to deny payment for services found to be unnecessary.

The basic thrust of the legislation is to control admissions and utilization. It is believed that in this fashion Medicare and Medicaid will become cost effective. PSROs will be phased out and replaced by statewide PROs. Health care facilities specifically are excluded from acting as PROs. The PROs, however, are authorized to subcontract some or all of the functions to hospitals without running afoul of the statutory exclusion. Ultimate responsibility for the review activity must remain within the PRO.

The ability to delegate review to hospital committees is limited somewhat in New Jersey since the state government, through the Division of Medical Assistance, Department of Human Services, will not permit delegation for Medicaid cases. State law does permit delegation under the DRG program for all non-Medicaid reviews.

While federal law is phasing out PSROs as such, it has replaced them with a PRO of statewide significance. This is an interesting turnabout. When the PSRO legislation originally was being considered, Congress determined that PSROs should function on less than a statewide basis, even though the medical profession advised that a single statewide organization would assure quality, consistency, and economy in the review process. Today, Congress has ruled "statewide" is better.

Regardless of the format, delegation as such is of vital importance to our physicians and hospitals, and the presently forming PRO in New Jersey must be encouraged to make maximum use of responsible delegation.

*The material for this column is coedited by Arthur Krosnick, M.D., Editor, *The Journal*, MSNJ; Vincent A. Maressa, M.D., Executive Director, MSNJ; and James E. George, M.D., J.D., Director of Professional Liability, MSNJ.

TAX SHELTERS

Just one of the personal financial services available to you from the ***physician's bank.***

- tax planning
- lines of credit
- equipment financing
- retirement planning

- money management
- cash flow • investments
- estate planning

Call or Write
Joseph J. Verbaro, Jr.
Senior Vice President
(201) 228-9770

FINTRUST
FINANCIAL AND TRUST SERVICES
DIVISION OF SECURITY NATIONAL BANK & TRUST COMPANY OF NEW JERSEY
101 Eisenhower Parkway
Roseland, New Jersey 07068 Member F.D.I.C.

MEDICAL COMPUTERS
DEC - IBM - TELEVIDEO

THINKING OF COMPUTERIZING YOUR PRACTICE?
FBL MEDICAL COMPUTER SPECIALISTS offers a wide variety of hardware/software configurations for every medical office size and application.

- AUTOMATIC INSURANCE FORM PREPARATION
- ACCOUNTS RECEIVABLE CONTROL
- AUTOMATIC PATIENT RECALL
- PRACTICE MANAGEMENT REPORTS
- CLINICAL RECORDS
- APPOINTMENT SCHEDULING
- ELECTRONIC CLAIMS SUBMISSION
- WORD PROCESSING
- MEDICARE/MEDICAID BILLING
- GENERAL LEDGER

FREE OFFICE ANALYSIS AND CONSULTATION – NO OBLIGATION

FBL

PROVIDING YOU WITH OVER 15 YEARS OF MEDICAL COMPUTER EXPERIENCE

3 ROUTE 46W, FAIRFIELD, N.J. 07006 201-882-9210

Doctors: Write your own prescription to cure insurance pains . . .

℞ Prescription

Name MSNJ Member

MSNJ Group
Blue Cross/Blue Shield Major Medical and Dental Insurance

that provides:

- **Flexible plans**
- **Comprehensive benefits**
- **Low, competitive rates**
- **Centralized Administration**

Designed and Administered by
DONALD F. SMITH & ASSOCIATES

℞ Prescription

Name _____

Address _____

Phone _____

Please send more information on the MSNJ

- ☐ Blue Cross/Blue Shield Program
- ☐ Major Medical Program
- ☐ Group Dental Program

Return to:
Donald F. Smith & Associates
One Airport Place, Route 206 North
P.O. Box 2197,
Princeton, New Jersey 08540
(609) 924-8700, (201) 622-6046

ERIATRIC IMPERATIVE: SHOULD COMMUNITY OSPITALS HAVE GERIATRIC UNITS?

CHAEL A. NEVINS, M.D., WOODCLIFF LAKE*

ne modern hospital can be a hostile environment for the frail derly. A potential solution to this problem is to develop special are units designed to being sensitive to patients' unique needs, minimize the hazards of hospitalization, and to maintain eneral function as acute illness is being treated.

Between 30 and 50 percent of all acute hospital beds currently are occupied by patients over 65. Not only do older patients have disproportately more hospital admissions, but their duration cost of stay substantially are greater than that of ger groups. In assessing contemporary hospital tric care, neither unqualified endorsement or in- ient would seem to be appropriate. Perhaps it d be best to begin by considering whether our iling system in this country, in which all acutely tients spatially are integrated, works optimally of the time.

course, age, per se, should not be the issue since persons of even far advanced age retain their al and physical faculties so that they are quite pendent and need not be treated differently. The tional definition of geriatrics as over 65 is arbi- and inadequate, there being little that dis- ishes special needs of the decade beyond 65 from just before it. After age 75, however, health and nosocial problems begin to accelerate and com- d to the extent that many of the advanced elderly to arrive at a symbiotic relationship with their ic infirmities, the event that causes acute hospi- tion being but the last of a series of setbacks. efore, function rather than age should be the al determinant that characterizes the geriatric nt.

The acutely ill geriatric patients typically have diminished physiologic reserve and decreased capacity to adapt to unfamiliar surroundings which puts them at increased risk of complications. As a result, the modern hospital with its disease orientation and fixed methodology often is a hostile environment for the frail elderly. Early studies suggested that the complication rate on general medical wards was twice as great for patients over age 70 and that nearly 40 percent encounter iatrogenic problems such as reactions to medications or procedures, accidental trauma, hospital-related psychologic decompensation, or nosocomial infection.[1] A recent study of 279 patients age 70 or more at a 400-bed community hospital found considerable age-related disability with more than half of those 75 years or older needing activities of daily living (ADL) assistance, about two-fifths receiving psychotropic medications, and one-fifth incontinent and in need of catheters.[2] Over age 85, 54 percent were moderately or severely disoriented, 34 percent had impaired hearing, 40 percent had impaired vision, and 25 percent had a speech impairment.

Is it any wonder that already overburdened nursing staffs often are frustrated and hard pressed to attend to the added needs of many elderly patients and express the need for additional help? The present hospi-

*Dr. Nevins is Governor, New Jersey Chapter, American College of Physicians.

tal system, however, responds poorly to this need; a common response is to distribute the oldest patients around so as, at least, to share the extra work equitably.

One potential solution to this universal problem is to develop special care units for certain categories of the elderly; in such units, sensitivity to the patients' needs might minimize the hazards of hospitalization and maintain general function even as acute illness is being treated. Although conceptually this is an attractive idea, there are distinct pitfalls to successful implementation. Many instructive models are available from which to learn, notably from Great Britain, Canada, Europe, and Israel where geriatrics units are common. Recently, several centers in the United States have developed.

In this country, most innovations in geriatrics have occurred in larger teaching hospitals, one variety being the roving team approach where small multidisciplinary groups seek out patients on conventional wards to provide consultative and educational services.[3] Geriatrics units which are directly responsible for inpatient care essentially can be considered as one of the following two basic models:

1. Postacute Care. Patients are accepted into the geriatric unit only after acute illness has been stabilized, the major emphasis being on rehabilitation and avoidance of long-term institutionalization. One example at the Sepulveda, California VA Hospital that is proving to be "cost effective" was described by Rubenstein.[4] Lefton et al. also have found that overall function of elderly patients was improved when treated on a multidisciplinary geriatric unit, weeks to months after a catastrophic acute illness.[5] The determination of unit effectiveness depends substantially on the selection of patients and their premorbid functional status. In this respect, the ideal candidate would be one who was reasonably well before developing an acute illness, such as a stroke, who after concentrated rehabilitative effort is able to return home.

2. Day-One Units. These provide all the services of any conventional acute medical-surgical unit but may have different orientation, operating policies, and staffing patterns. Patient demography, of course, varies with the local ground rules. At Shaare Zedek Medical Center, Jerusalem, where admissions are at the discretion of the resident staff and according to bed availability, those patients admitted to acute geriatrics rather than general medicine tend to be more functionally disabled in regard to mobility, mental state, and continence.[6]

In this country an outstanding example of comprehensive geriatric care at a 200-bed community hospital is the unit developed by Albert A. Fisk, M.D., at the Wisconsin Regional Geriatric Center, Milwaukee.[7] In a personal communication, Fisk noted that his original conception for a geriatric unit primarily was from an educational benefit point of view, but as time went on it became apparent that the unit had a great deal more value:

"When an elderly patient is hospitalized, the medical problem is most likely to be just the tip of the iceberg and a host of psychosocial problems frequently accompany the acute medical problem. Developing a team to address these different problems, therefore, is the major object in developing an acute care geriatric u This is not at all easy. Over a period of two years developed a very excellent team with a group of nu who were interested in and proud to be involve geriatrics. They developed some protocols for probl such as decubiti and constipation. The hospital the model of primary care nursing which seems t in very well with the needs of our patients. How one needs increased staffing and it particularly is visable to have aides available to assist in the ca some total care patients." Fundamental to the suc of the Wisconsin unit are weekly conferences which attended by the primary care nurses, the unit so worker, rehabilitation therapists, house staff and dents, pharmacists, social workers, and outpatient home care nurses. Communication at this m disciplinary conference is open, information is sha and decisions are arrived at mutually with the p sicians contributing to, but not dominating, the c ference.

A potential solution is to develop special care units designed to being sensitive to a patient's unique needs.

Another excellent "day-one" program is that of University of Massachusetts Medical Sch Worcester, where the Geriatric Care Unit directed Roger B. Hickler, M.D., provides a continuum of in- outpatient services including a 14-bed geriatric u (4 percent of the total hospital beds), an outpati clinic, and a community consultation and educatio resource team.[8] Potential admissions are screened staff members to avoid purely disposition proble but there are no other diagnostic exclusions; a three days, all patients are reviewed to evaluate appropriateness of their remaining on the u Special consideration is given to the frail elderly o years and older with a multitude of health proble and to the 25 percent of patients who have some fo of dementia. The average length of stay for the first 5 admissions over an 18-month period was 11.5 d and in each 5-year age group up to age 90 the len of hospitalization was equal to or shorter than tha the corresponding age group in the remainder of hospital.

It is difficult to enumerate the requisite compone of a successful geriatrics unit. Much depends upon nature of the institution and the extent of its comm ment. Nonetheless, whether conceived as a postac or a day-one unit, the following comments are releva

1. The traditional role of the primary care physic should be preserved, but a delicate balance must achieved whereby the unit staff attains sufficie autonomy to feel that they are valued participants the decision-making process. In this regard, the r of the unit director can be crucial not only as gatekeeper who assures that the unit does not evo into a disposition unit, but as a harmonizer who s that the integrity of unit policies is maintained.

Only to the extent that the nurse and support are professionally gratified can initial enthusiasm sustained and "burn-out" avoided. The geriatric is an example of "software" (people and policy) g more important than "hardware" (special equip- t).

Although relatively little special equipment is ssary, some geriatric units have pioneered in de- ping a therapeutic environment where wheelchairs restraints are uncommon and which serve to ance patient orientation, encourage activity, and note independence.[9,10]

Implicit to optimum geriatric care is an increased ortion of helpers to patients as compared to usual ing ratios. Advantage often can be taken of non- essionals, volunteers, and family in some roles. mitted full-time therapists and social workers can more efficiently in a special unit and satellite ities can obviate transport to distant parts of the ital.

In parallel to treatment directed against the ad- ing problem should be functional assessment so ot to lose ground early during the hospitalization. rts at rehabilitation should commence as soon as feasible. The causes of common problems such as decubiti, and incontinence should be sought, but ng and treatment initiated only if one can reason- expect a beneficial functional response.

The geriatric unit requires a cadre of skilled pro- onals who collectively may have a positive effect heir colleagues, not only by relieving them of per- d burdensome patients, but by their infectious usiasm and example. Also, the unit staff can serve resource group for intramural consultation and ation.

The community hospital has the personnel, ex- se, and support services to be the principal ider and coordinator of a broad spectrum of ser- and is the natural focal point for community ities that too often are fragmented. In order for t-term hospital benefits to be sustained, it is ssary to have a followup mechanism such as a tric outpatient clinic. Other modules of a com- ensive and integrated program might include services as a day hospital, day-care, or respite-

hough many of the advantages herein described d be accomplished in the context of a "geriatrics ce-without-walls," the likelihood of success is nced if the unit has a specific place where equip- t and personnel efficiently can be concentrated and nurses have primary care responsibility. Ultimately, the crucial element is people: without a staff that is affirmative, optimistic, innovative, and professionally fulfilled, a geriatric unit is unlikely to achieve its full potential.

Finally, it should be noted that progress and dialogue in this field have been inhibited to an extent by several perceptions that have made geriatrics units a "bogeyman" of sorts. Some skeptics have viewed geriatrics units as potential repositories for the terminally ill or for disposition cases. No doubt, some internists and family practitioners feel threatened by the emergence of a new breed of geriatricians as still another incursion on their turf. Nursing administrators have expressed concern about motivating their staffs to work in areas which traditionally have been considered to be frustrating and professionally unrewarding. Hospital administrators, in turn, understandably are cautious about initiating potentially expensive and unproved new projects in an era of increased financial regulation and cost containment. All of these legitimate concerns must be addressed if the future practice of hospital geriatrics is to change appreciably. Nonetheless, change it must.

The ubiquitous presence on general medical wards of confused, elderly patients, posed in "gerry-chairs" and positioned in the midst of nurses' stations for direct observation serves as a haunting and compelling example of the bankruptcy of our present system and the need for taking a fresh look at certain long-standing traditions of hospital care.

REFERENCES

1. Reichel W: Complications in the care of 500 elderly hospitalized patients. *J Am Geriatr Soc* 13:973, 1965.
2. Warshaw GA, Moore JT, Friedman W, Currie CT, Kennie DC, Kane WJ, Mears PA: Functional disability in the hospitalized elderly. *JAMA* 248:847-850, 1982.
3. Blumenfield S, Morris J, Sherman FT: The geriatric team in the acute care hospital. *J Am Geriatr Soc* 30:660-664, 1982.
4. Rubenstein LZ, Abrass IB, Kane RL: Improved care for patients on a new geriatrics evaluation unit. *J Am Geriatr Soc* 29:531-536, 1981.
5. Lefton E, Bonstelle S, Frengley JD: Success with an inpatient geriatric unit. *J Am Geriatr Soc* 31:149-155, 1983.
6. Greenberg NS, Rosin AJ: Factors influencing admissions or nonadmissions of the aged to the hospital. *J Am Geriatr Soc* 30:635-641, 1982.
7. Fisk AA: Comprehensive health care for the elderly. *JAMA* 249:230-236, 1983.
8. Hickler RB: Personal communication, 1983.
9. Gundby P: Gerontology unit focuses on mobility, not restraint. *JAMA* 249:1249-1250, 1983.
10. Cape RDT: Personal communication, 1983.



Angina Protection with Benefits for a Lifetime

ONCE-DAILY CONTROL WITH HEART-SAVING BENEFITS

By reducing heart rate and cardiac contractility, INDERAL LA helps protect the heart from the potentially serious and debilitating consequences of ischemia. A highly effective antianginal agent for around-the-clock control of symptoms, INDERAL LA also provides cardiovascular protection for a sense of security in the years ahead.

PROTECTION AND EXPERIENCE NO CALCIUM BLOCKER CAN MATCH

Unlike calcium blockers, INDERAL LA—either alone or with a nitrate—is recommended for early treatment of angina in the majority of patients. Equally important, INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use.

START WITH 80 MG ONCE DAILY

Dosage may be increased to 160 mg once daily, as needed, to achieve optimal control. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY **INDERAL LA** (PROPRANOLOL HCl) *LONG ACTING CAPSULES*



Ayerst®

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

JUST ONCE EACH DAY FOR SIMPLIFIED CORE THERAPY IN ANGINA

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking th prior to major surgery is controversial. It should be noted, however, that the impaired ab the heart to respond to reflex adrenergic stimuli may augment the risks of general anest and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of receptor agonists and its effects can be reversed by administration of such agents, dobutamine or isoproterenol. However, such patients may be subject to protracted s hypotension. Difficulty in starting and maintaining the heartbeat has also been reporte beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent th pearance of certain premonitory signs and symptoms (pulse rate and pressure chang acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroi Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symp of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have reported in which, after propranolol, the tachycardia was replaced by a severe bradyc requiring a demand pacemaker. In one case this resulted after an initial dose of propranolol.

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with imp hepatic or renal function. INDERAL is not indicated for the treatment of hyperte emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Pa should be told that INDERAL may interfere with the glaucoma screening test. Withdrawa lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart dis elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as pine should be closely observed if INDERAL is administered. The added catechola blocking action may produce an excessive reduction of resting sympathetic nervous a which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or ortho hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals been conducted to evaluate toxic effects and carcinogenic potential. In 18-month stud both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of signi drug-induced toxicity. There were no drug related tumorigenic effects at any of the do levels. Reproductive studies in animals did not show any impairment of fertility tha attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryoto animal studies at doses about 10 times greater than the maximum recommended human

There are no adequate and well-controlled studies in pregnant women. INDERAL s be used during pregnancy only if the potential benefit justifies the potential risk to the

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; l tension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by inso lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; disturbances; hallucinations; an acute reversible syndrome characterized by disorientati time and place, short-term memory loss, emotional lability, slightly clouded sensorium decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diar constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with a and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytop purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male tence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reac involving the skin, serous membranes and conjunctivae reported for a beta blocker (prac have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochlorid sustained-release capsule for administration once daily. If patients are switched from IND tablets to INDERAL LA capsules, care should be taken to assure that the desired therap effect is maintained. INDERAL LA should not be considered a simple mg for mg substitu INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration be necessary especially to maintain effectiveness at the end of the 24-hour dosing int

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 8 INDERAL LA once daily, whether used alone or added to a diuretic. The dosage m increased to 120 mg once daily or higher until adequate blood-pressure control is achi The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage mg may be required. The time needed for full hypertensive response to a given dosa variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDER once daily, dosage should be gradually increased at three to seven day intervals until opt response is obtained. Although individual patients may respond at any dosage leve average optimum dosage appears to be 160 mg once daily. In angina pectoris, the valu safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few w (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDER once daily. The usual effective dose range is 160-240 mg once daily. The dosage m increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response obtained within four to six weeks after reaching the maximum dose, INDERAL LA th should be discontinued. It may be advisable to withdraw the drug gradually over a per several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group a limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laborat

8833

Ayerst® AYERST LABORATORIES
New York, N.Y. 10017

GERIATRIC IMPERATIVE: THE INTERFACE BETWEEN THE ACUTE HOSPITAL AND LONG-TERM CARE

WILLIAM J. KANE, M.D., AND DAVID C. KENNIE, M.G., CH.B., MOUNT HOLLY*

The potential for increasing health care costs to a growing elderly population is staggering. We propose the creation of an acute geriatric unit and an examination of the hospital role in long-term care.

In the last few years, medical education has begun to address the needs of physicians for ecific skills and knowledge in the care of the aged tient. Yet, in the absence of an appropriate care de- ery system, the individual physician, no matter how illed, is limited in his/her ability to deliver quality re to the elderly. The appropriateness of the health re delivery system is more important for this age oup than for any other subpopulation; therefore a reful examination of the role of the acute hospital necessary.

A health care system for the elderly must develop thin constraints imposed by a modern competitive ciety. The development of a comprehensive system l be stimulated by two factors, cost and the impedi- nt to the efficient function of the acute hospital. Total costs of Medicaid, the biggest provider of long- m care, have risen from 1.3 billion dollars in 1965 18.6 billion dollars in 1978. Forty-one percent of this ount went to nursing home care.[1] With the number elderly in the population doubling in the next 50 rs, the potential for increasing health care costs is ggering. As the cost and complexity of acute hospi- care continues to increase and prospective reim- rsement gains momentum, elderly patients awaiting nsfer to long-term care facilities become a major blem. In selected areas of the United States, es- ially in our urban areas, the problem is just begin- ning. In New York, it was found that Medicare and Medicaid recipients made up 55.6 percent of the occupants of acute care beds and that almost 11 percent of these were awaiting transfer to nonacute facilities.[2] In Massachusetts, in 1983, it was found that 823 elderly patients were awaiting transfer on any given day and that this amounted to almost 300,000 patient days annually in that state alone.[3]

If we are to have a comprehensive but reasonable health care system for the elderly which addresses both cost and blocked beds, more attention must be paid to hospital care of the aged. Much effort has been expended to identify high-risk elderly in order to keep them at home and to prevent institutionalization. It often is difficult to identify and intervene with those elderly at risk because the major precipitating factor nearly always is illness with the secondary effects of illness or trauma on function. Often, the common denominator is an admission to an acute-care hospital which unfortunately often is prepared poorly to care for the frail, impaired, elderly patient. The patient's level of functional ability is allowed to deteriorate in the hospital so that the patient no longer can cope with the premorbid level of community support.

*Dr. Kane is Vice-President, Medical Affairs, Memorial Hospital of Burlington County, Mount Holly, and Dr. Kennie, is Consultant Geriatrician, Stirling Royal Infirmary, Stirling, Scotland.

The considerable extent of functional impairment among the elderly in hospitals previously has been shown.[4] A recent survey, on which the authors collaborated, examined patients 70 years and over in a 400-bed community hospital affiliated with a university medical center. The study found that more than half of the patients 75 years or older needed assistance with activities of daily living; 34 percent had impaired hearing, 40 percent had impaired vision, and 25 percent had speech impairment. Fifty-four percent of patients aged 85 and older were moderately or severely disoriented. Incontinence of urine or stool was present in 21 percent of the patients. Physical therapy was ordered on only 30 percent of the patients and social services were involved in only 40 percent of the admissions, largely for discharge planning.[5]

The acute hospital does not cope well and was not designed for the elderly patient. Today, the patient usually is confined to a single room, which may be a form of sensory isolation. Any pre-existing confusion may be aggravated. Existing policy does not make it convenient for patients to walk about and in order to achieve conformity with rigid hospital systems, physical or chemical restraint often is imposed. In the survey quoted previously, psychotropic medications and sedatives were being prescribed for 43 percent of the patients over the age of 70. Impaired mobility and incontinence often were a consequence of this restraint.

Because of the special needs of hospitalized elderly patients, we advocate the creation of a functionally oriented unit as a discrete area in the hospital where the needs of the very old can be met by a combination of correct policy and suitable environment. Such special units already exist in our hospitals for pediatric, obstetric, and psychiatric patients.

This acute unit would have a comprehensive assessment and triage system to meet the medical, functional, and support needs of the elderly patient. Policy would seek the promotion of independence rather than dependence. Physical therapy would take place within the unit and on a repetitive basis throughout the day rather than in one short session in the physical therapy department. The staff would form a multidisciplinary team and spend additional time working with families and the attending physician in discharge planning. Teamwork with regular case conferences and close scrutiny of drug prescribing also would be a part of this unit. Nursing staff would be selected and rewarded for expertise in geriatric care, achieving clinical distinction as in critical care and maternal and child health.

An evaluation of this concept absolutely is necessary to prove its superiority to a regular medical/surgical unit. Parameters such as level of function at discharge for any diagnostic group, the rate of discharge to nursing homes, the use of physical and chemical restraints, cost, patient and family satisfaction, and staff attitudes and approach to the elderly could be measured.

While many aged patients can be discharged successfully to the home within several days from a functionally oriented hospital unit, some will not and they will require longer periods to regain their full potential. Examples of such patients would be stroke patients with barriers to rehabilitation and patients with amputation or hip fractures with cardiorespiratory pr lems or resolving confusional states. Such patie may have no long-term need for a nursing home. must examine our long-term care facilities and t success in rehabilitation and return of the elderly the community.

The usual nursing home does not focus sufficie on the elderly with rehabilitation potential. Most fa ties mix patient groups. Elderly patients with se dementia who are confused and restless are mi with patients who are seriously ill requiring parent nutrition, turning, and vital signs. Frequently sa wiched between these two is the elderly patient w a mild stroke and good prognosis. Despite this pr nosis, recovery and discharge may be impeded beca simple rehabilitative measures will be difficult du the excessive strain on staff time imposed by the ot two patient groups. The conventionally protect nature of nursing care required for these very dep dent patients also detracts from the rehabilitat where the patient is encouraged to be an active part pant and take care of him- or herself.

There must be much more careful multidisciplin assessment of patients entering the nursing ho Specific attention must be paid to the rehabilitat potential and to consideration of placement in a tinct area of the facility. These patients would be gi a definite period of time in such an area to achi discharge or independence and after that time be

A system must be designed to control the cost of health care for the elderly while improving the quality of care.

located in the facility. This rehabilitation unit with the nursing home would be protected bed space a would never operate at full occupancy. In this w patients could be transferred readily from the hospi and continual turnover would occur.

To develop the acute hospital unit and the rehab tation unit within the nursing home, reimburseme incentives will have to change. In the hospital, thi party payors may have to pay slightly more for hospit ization to reduce the need for long-term care. In t nursing home, adequate reimbursement will have be available to provide rehabilitation to those patie with excellent potential. In addition, nursing hom will have to receive some incentive to encourage retu to the community rather than the current situati which financially encourages nursing homes to ke their beds full with the least disabled patient for t longest period of time.

In addition to changes, within the acute hospital a the long-term care facility, a supportive commun environment will have to be maintained. Better resp for families, adequate home care, and other servic are essential. Such services should be allocated or after multidisciplinary assessment, including a kno edgeable physician, determines true need. The curre situation allows need to equal demand and, often, tr

eedy patients do not receive a service because it is ing given to less needy patients who have better cessibility or competent advocates such as family or cial services.

JMMARY

A system must be designed to control the cost of alth care for the elderly, while improving the quality care. Hospitals now are faced with a Medicare pro-ective reimbursement system which requires a new id comprehensive look at services delivered to elderly tients. This paper suggests two changes. The first a change in hospital services to accommodate the derly who because of illness or trauma are admitted a hospital and who must have their function main-ined to achieve discharge back to the community. condly, hospitals must foster changes in long-term re to increase rehabilitation and provide quicker and ore frequent return to the community of the elderly ith the potential to do so. Multidisciplinary assess-ent in the hospital, in the community, and in the ng-term care facility will be necessary to accomplish these goals. By carefully examining the interface between the acute hospital and long-term care in the community and in the nursing home, hospitals successfully can deal with prospective reimbursement, prevent blocked beds, and, in the long run, provide better care for the elderly in their community.

REFERENCES

1. Health Care Financing Administration Medicaid Statistics, 1978. DHEW Publication Number (HCFA) 78-03154.
2. New York Statewide Professional Standards Review Council, Inc.: Report on a statewide survey of patients awaiting placement for alternate care facilities in New York state. New York, NY, June 1979.
3. Campion EW, Bang A, May MI: Why acute care hospitals must undertake long-term care. *N Engl J Med* 308: 71-75, 1983.
4. Donahue W, et al.: Rehabilitation of geriatric patients in county hospitals. *Geriatrics* 263-274, 1960.
5. Warshaw G, et al.: Functional disability in the hospitalized elderly. *JAMA* 248:847-850, 1982.
6. Winston R, et al.: External peer review of skilled nursing care in Minnesota. *Am J Pub Health* 66:278-283, 1976.

Motrin®
ibuprofen, Upjohn
600 mg Tablets



More convenient for your patients.

Upjohn

©1984 The Upjohn Company

The Upjohn Company • Kalamazoo, Michigan 49001 USA

J-4044 Jan

GERIATRIC IMPERATIVE: AN OPPORTUNITY FOR CHANGE

RONALD B. MILCH, PASSAIC*

A re-examination of the roles of hospitals and physicians is needed for success in meeting the health care demands of a growing elderly population, with as much emphasis required on extended and essentially palliative care as on acute, curing care. General recommendations and specific changes are described.

The growing number and percent of older Americans has produced a steady rise in the demand for health care services and pressure for change the way they are provided.

Anne Somers and others refer to the health care field facing a "geriatric imperative" and warn that effective responses are overdue.

This article describes how the geriatric imperative is addressed by the Committee on Aging and Long-Term Care of the New Jersey Hospital Association (NJHA)—a committee the author chaired—and then goes on to summarize some of the activities undertaken at Beth Israel Hospital, Passaic, and the direction in which we expect to travel in the future.

After more than a year of research and reflection, the committee established by NJHA to consider the role of hospitals in serving the elderly decided that it was important to prescribe norms as it was programs. In fact, it was the Committee's view that the overall intent was more important than specific activities. The Committee selected four elements for focus by the New Jersey hospital industry and an additional one for individual hospitals and their chief executive officers (CEOs): In terms of the New Jersey hospital industry, the Committee urged:

1. The industry must encourage professional education in geriatric care in both professional and continuing education and foster research in geriatric care.

2. The industry must support changes in state and federal laws and regulations that reduce the institutional bias of current reimbursement programs, support alternative services, require financial impact studies of existing and proposed licensure regulations, and centralize state funding of care for aged and chronically ill. The Committee also urged tax credits for family support systems and a state system for developing diagnostic data for patients on the Medicaid nursing home waiting list.

3. NJHA should establish a standing committee on aged and chronically ill, establish positions on case mix reimbursement system for long-term care facilities, and on other policy matters, including insurance for long-term care, copayment for Medicare, and family supplements for Medicaid benefits.

4. Hospital-sponsored research should be encouraged through the Health Research and Educational Trust (HRET) of New Jersey, with certain specific activities accorded high priority: a study of the sensitivity of the DRG system to age of patients, development of a statewide directory of hospital programs for older adults and a manual of program prototypes and other resources, and, finally, a broad study of the impact of a growing geriatric population on hospital operations.

In terms of individual hospitals and their CEOs, the

*Mr. Milch is Executive Director, Beth Israel Hospital, Passaic.

Committee urged each to do the following:

1. Establish geriatric care as a high priority by recognizing the geriatric population as a growth portion of health care business, by conducting appropriate local marketing studies and by working to differentiate between patient needs and patient wants.

2. Establish geriatric care standards. Each hospital should establish geriatric care committees, including professional staff of all disciplines, to recommend hospital policies and procedures and develop approaches to change in existing services, such as geriatrics medical/surgical units or other selected geriatric care programs.

3. Promote standards of geriatric care. The Committee felt this could be accomplished best by conducting a hospital-wide analysis, including surveys of staff attitudes and aptitudes, and by providing inservice training.

4. Assume community leadership role by conducting assessments of community services and participating in case management systems. The Committee felt it was time for hospitals to establish broader links to community-based agencies and to help facilitate interaction between hospitals, physicians, and community agencies.

At Beth Israel Hospital, the geriatric imperative has been an important part of planning since the middle 1970s and we believe we have successfully converted the challenge presented by the elderly into a plus for the hospital, at least for the mid-term.

However, a re-examination of the role for which most hospitals believe they were created is required for long-term success.

BETH ISRAEL HOSPITAL

The 223-bed Beth Israel Hospital, Passaic, shares a service area of less than 180,000 persons with two larger hospitals, each less than two miles distant. Additional competition is offered at the edges of the area by other hospitals. The 1980 Census found population in the area declined 7.6 percent and state planners forecast somewhat smaller losses in the decade ahead. Passaic—the core city in the service area—showed decreases in both number and percent of the elderly although the picture was balanced somewhat by gains in the neighboring city of Clifton.

In the face of the stiff competition and lack of population growth—including that of the elderly population—Beth Israel Hospital has improved its utilization, developed new and expanded services, added to its medical staff, improved its operating margins, and undertaken a major modernization program that place the hospital in a sound competitive position for the 1980s.

The hospital's accomplishments were not accidental. They were based on a continuous long-range planning process conducted at the Board of Trustee, CEO, and medical staff leadership levels that helped frame policy questions and clearly articulate policy decisions.

We began by affirming that Beth Israel Hospital was more than an acute care institution. We consider our hospital a community "helping" resource, rather than an institution organized solely to provide acute medical care. We want to serve through a variety of health and health-related activities. Railroads viewed t selves too narrowly. They considered themselves systems, rather than transportation systems; it them dearly. We feel hospitals ought not to repeat kind of mistake.

We accepted the "geriatric imperative" as real mirrored in our overall service area, if not in the area in which the hospital itself is located. We ack edged that elderly patients were key customers likely to remain so. They were not a special mi group. They were the solid base of our patient

Confronting the geriatric imperative means that the changes underway are mor in the nature of obligatory acts.

Over a period of five years we have expanded developed the following to help serve them:

- A Beth Israel-based, tri-hospital home care gram.
- A hospice home care extension.
- A Personal Health Service homemaker pro intended for self-pay patients and for eventual agement as a separate, for-profit corporation.
- A Community Health Service, emphasizing munity health education and outreach service.
- Agreement with the medical staff to establis campus primary care centers, including at least emphasizing gerontological care.
- Corporate restructuring to permit new ventur housing for the elderly, sheltered care, day care, life care.
- Awareness of the needs of the elderly in the rier-free design of the major renovation and ernization program at the hospital.
- Changes in professional and other staff trai to emphasize the needs of the elderly.

Other specific elements were added as well. include senior feeding (kosher meals, special diets other foods for the elderly in several surrou towns), podiatric care, and a community lifeline gram, coordinated through the hospital's emer room.

Have the activities been of benefit to the hos The indicators are positive. From 1977—shortly the commitment to confront the geriatric perative—through 1981, the hospital's occupancy went from 70.9 percent to 80.8 percent, as admis rose from 7,400 to 7,900 in an area that was exper ing an overall loss of population. Neighboring hosp grew at less than half the rate of Beth Israel Hos The elderly played a significant role in the Beth I Hospital improvement: Medicare days rose fro percent of all days in 1977 to 50 percent of all in 1981 and an indicated 52 percent in 1982.

Home care visits rose from 25,000 in 1977 to 5 in 1982, not including visits by the Personal H Service established for self-pay patients. Last home care generated outpatient revenues of more two million dollars.

The effort goes on. Planning, implementation, evaluon, and replanning proceed in a continuous loop. t everything goes well. Not all projections are met. Looking into the future we see hospitals, particularly ose in the older, more stable suburbs, remaining cial to any improved system of care for the elderly. me believe hospitals to be largely irrelevant to the ronic care needs of the elderly. We disagree. Hospis are highly visible and available 24 hours a day, ven days per week, every week of the year. They are d will remain prime points of access, as will doctors' ices. In time, the hospital role may shift and lead to reater emphasis on gatekeeping: assessing the over- needs of geriatric patients and coordinating the rious medical, social, and other services required as e patient steps through the gate into a more rational, ng-term care system.

Certainly, hospitals will be more involved in primary d preventive care for the elderly, either directly or in peration with those members of its medical staff o orient their practice to the elderly. We also will gin to mass services required to stabilize the acute isodes of those with chronic illness while becoming re deeply involved in rehabilitation and transition home.

Furthermore, in exercising our responsibility to the lerly, all of us in health care must come to appreciate at many needs are psychological and social in nature well as physical—and that these elements are inparable from the care we provide. As a result, services the elderly will be provided by many disciplines and fessions, functioning through multiple agencies. A ccessful health system for the elderly will require the critical mass of management skills of a hospital to effectively coordinate all those resources, whatever their configuration.

Hospitals can provide service directly and they will. They can provide space within the hospital complex for others to offer services and many will. Indeed, the new administrative technique of organizing the hospital into a holding company, with individual corporate entities formed around disparate but related functions, has promise for enabling hospitals to greatly broaden their ability to plan and participate, whatever the service, whoever renders it, or wherever it is located.

SUMMARY

Hospital personnel and physicians are trained to provide acute, curing care. However, the inevitable consequences of aging have forced our single biggest users—the elderly—to become purchasers of care that is extended and essentially palliative, and, as they say in the marketing terms currently fashionable in hospital circles: "What you are selling is less important than what people are buying."

It is a considerable change for hospitals and for doctors but it is one demanded by the needs of the people we serve—it is demanded by the geriatric imperative.

In short, confronting the geriatric imperative means that the changes underway in how we treat the elderly are more in the nature of obligatory acts—ones we cannot and should not avoid or evade.

Hospitals and doctors that adapt best to these obligations are those most likely to succeed and prosper in the years ahead.

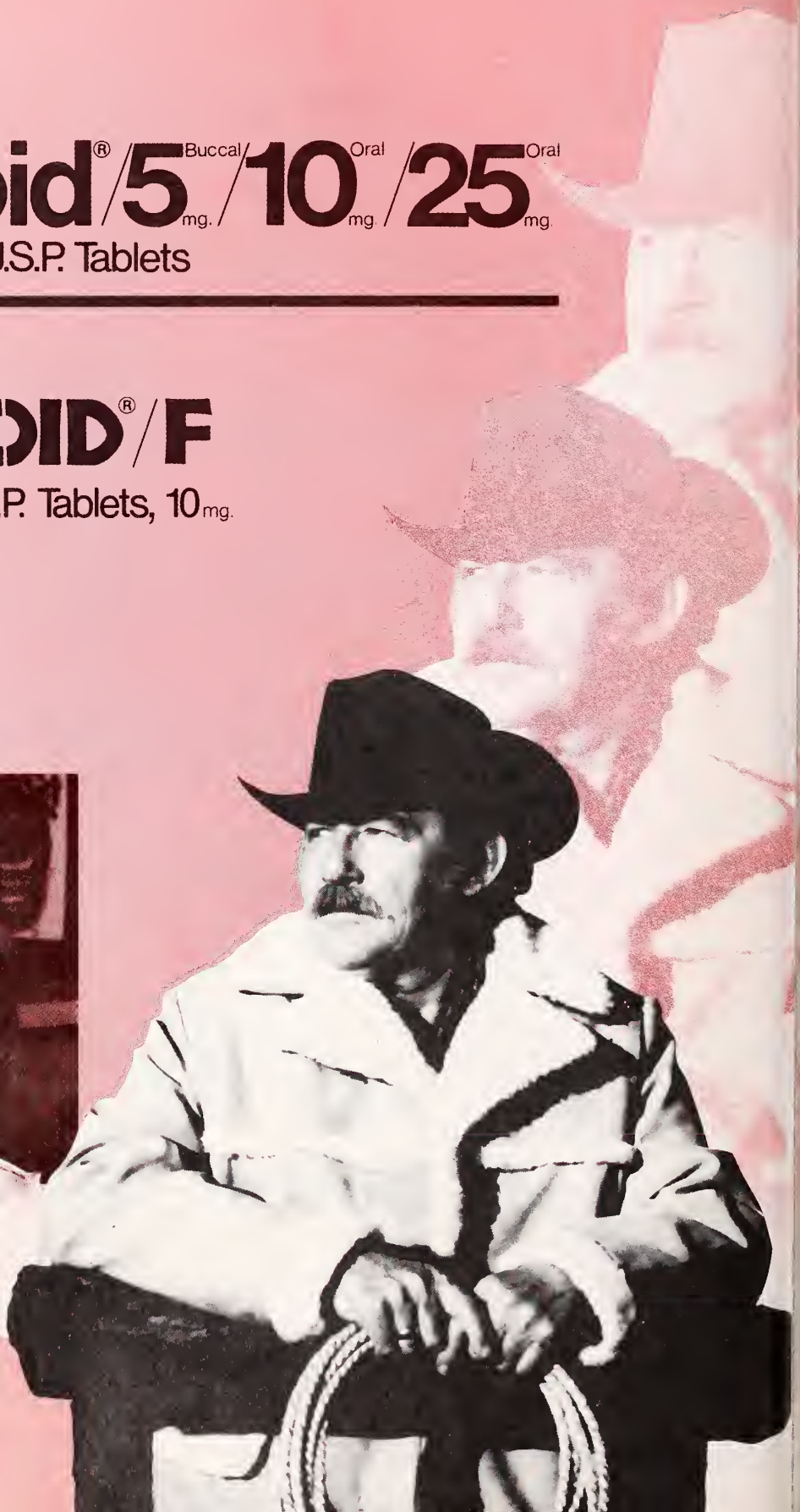
BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android®/5 mg. Buccal/10 mg. Oral/25 mg. Oral
Methyltestosterone U.S.P. Tablets

ANDROID®/F
Fluoxymesterone U.S.P. Tablets, 10 mg.





ERIATRIC IMPERATIVE: ERIATRIC ASSESSMENT PROGRAMS

LAURENCE Z. RUBENSTEIN, M.D., M.P.H., SEPULVEDA, CA*

This article reviews geriatric assessment programs and their history, purpose, structure, and the growing indications that they are effective in producing improved health care outcomes such as better diagnoses, reduced nursing home placement, decreased medications, and higher functional status levels.

Growing awareness of the vast numbers of unmet health and psychosocial problems faced by derly individuals, has led medical care providers to tablish special programs to comprehensively assess d treat elderly patients. This presentation will ovide a geriatrician's perspective on geriatric sessment programs by describing: (1) the purposes assessment; (2) the different structural and func- nal components of assessment programs; (3) exam- es of existing programs; and (4) some of the evidence at these programs are achieving their goals.

Geriatric assessment has several major purposes. ese include diagnosis and establishing baseline ta for documenting change, planning for therapy d for most appropriate services, and determining timal placement. Diagnosis means medical agnosis as well as the functional, psychologic, and cial diagnosis. This especially is important in light the accumulating evidence that elderly individuals ten are diagnosed incompletely and inaccurately en cared for in the usual medical setting without special geriatric approach. Careful, systematic sessment can lead to the discovery of important, eviously unrecognized, treatable problems.

Avoidance of inappropriate use of health care ser- es, especially those in institutions, has been a major jective of most geriatric assessment programs on ounds of both compassion and cost. Several studies summarized in the United States Government Accounting Office Report of 1979 concluded that at least 20 percent of patients in skilled nursing facilities and over one-third of patients in intermediate care facilities receive unnecessarily high levels of care.[1] Such inappropriate use is undesirable for several reasons, including wastefulness of scarce resources, creation of further disability by premature labeling of a person as irremediably ill, and iatrogenic illness which is common within institutional environments. There is substantial and growing evidence that assessment can lead to improved appropriateness of placement.

HISTORY OF GERIATRIC ASSESSMENT

The first published reports on geriatric assessment programs came from Great Britain. Dr. Marjorie Warren, a physician considered one of the founders of modern geriatrics, initiated the concept of specialized geriatric assessment units during the late 1930s while in charge of a large London infirmary. This infirmary was filled primarily with chronically ill, bed-fast, and largely neglected elderly patients who had not received proper medical diagnosis or rehabilitation. The high quality of the nursing kept the patients alive while the lack of diagnostic assessment and rehabilitation kept them disabled. Warren systematically evaluated these

*Dr. Rubenstein is Chief, Geriatric Evaluation Unit, VA Medical Center, Sepulveda, California.

TABLE 1

Geriatric Assessment Programs: Characteristics and Variants

Intended function
- Assessment
- Rehabilitation
- Acute or chronic treatment
- Placement
- Education
- Research

Location/setting
- Acute hospital
- Chronic hospital
- Long-term care facility
- Outpatient clinic or office
- Freestanding unit
- Patient homes

Patient source
- Community (direct application or referral)
- Acute hospital
- Long-term care facility

Inclusion criteria for patients
- Minimum age (e.g. ≥ 65, ≥ 75)
- Type of problem (e.g. psychiatric, placement)
- Degree of disability (e.g. inability to function independently)

Exclusion criteria for patients
- Poor prognosis
- Unstable condition

Organization
- Team composition
- Participating support service
- Size of unit
- Patient-to-staff ratio
- Payment source
- Followup capacity
- Time allowed for assessment

Approach to assessment
- Dimensions included
- Testing of actual performance *v* presumed capability
- Use of test batteries *v* clinical judgments
- Types of recordkeeping formats

patients and began policies of mobilization and selective rehabilitation. She was able to get most of the long bed-fast patients out of bed, often walking again and, in some cases, even discharged to home. As a result of her experiences, Warren became an advocate of comprehensive assessment and at least an attempt at rehabilitation of all elderly patients before sending them to long-term care hospitals.[2]

In the United States, geriatric assessment programs have emerged only in the past decade, however, their proliferation has been rapid in the last three or four years. These programs have a wide variety of structural and functional components, geared to differing types of populations and problems addressed, but they also share many common characteristics. Virtually all programs include the use of multidimensional assessment, utilizing one or more sets of measurement instruments to quantify functional, psychologic, and social parameters. Most of them use interdisciplinary teams to pool expertise and enthusiasm in worl toward common goals. Most attempt to couple t assessments with an intervention program, such rehabilitation, counseling, or placement.

PROGRAM CHARACTERISTICS

Some of the major characteristics which can between programs are listed in Table 1. A variet overall functions can be performed by these progra While assessment is common to all, many also inc treatment and rehabilitation; some include acute and most include the determination of optimal pl ment. Research and education are important asp of some programs, and generally have profound pacts on programmatic structure.

Program location largely determines the types of tients assessed and functions performed. Assessm programs in acute hospitals generally admit pati from acute inpatient services, though many also ac directly from the community if inpatient care is quired. Hospital programs usually combine treatm and rehabilitation with assessment and placem Outpatient clinics or freestanding units gene assess patients not requiring hospitalization usually do not perform substantial treatment or habilitation. Programs performing assessment in tient homes can obtain unique insights into how tients live and function at home, but the costs logistical problems associated with home visits l the size and scope of home assessment program

Referral sources for patients, as well as the clusionary and exclusionary admission criteria u by programs, also depend on the program setting intended functions. Although age criteria admitt are arbitrary, programs usually insist that patient at least 65 years old; some have a higher minimum to insure that the programs retain their "geria missions, and do not become programs caring for i viduals with chronic disorders of all ages. Some grams have geropsychiatric orientation and prima accept patients with problems such as dementia depression. Others, situated on acute medical serv accept patients with acute medical problems. M however, primarily accept patients with subacute chronic problems not requiring acute medica surgical hospitalization yet who are at great risk requiring long-term institutional care.

Programs providing substantial inpatient treatm or rehabilitation can increase their impacts by inc ing only patients with reasonable "rehabilita potential." However, prognostication is at best an i act art and every geriatrician knows many insta when patients not expected to do well have made markable recoveries. Some risks of failure mus taken, since accepting only patients expected to cover or rejecting patients on the basis of a poor p nosis easily can become self-fulfilling.

Organization of assessment programs varies siderably, but most include a core team of a physi or physician assistant or nurse practitioner, a nu and a social worker. To this core is added a variet other specialists, who either participate in the b assessment or are called in on a consultation basis psychologist, psychiatrist, occupational thera physical therapist, audiologist, dentist, optometris

hthalmologist, dietitian, public health nurse, and ners). The size of the team is influenced by several tors, including program goals, setting, patient load, d funding or reimbursement levels. Most funding urces and insurance companies have restrictive itations as to what services will be paid for and this ofoundly affects what services can be offered. How- r as evidence accumulates that these programs can cost effective, not only in improving quality of life t in reducing overall health care costs for the elderly, nding sources probably will expand.

Approaches to assessment vary between programs, pending upon programmatic goals and settings. st include a multidimensional assessment in which st or all of the areas of medical problems, functional abilities, psychologic status, and social network and eds are covered.

Table 2 lists the most important measurable nensions of geriatric assessment. Some programs e a comprehensive test battery or multidimensional sessment to achieve this, while others select from ong the existing unidimensional instruments best ted to their particular programs.

While geriatric assessment per se does not absolutely quire the use of specific instruments and scales, the e of easy-to-administer, well-validated assessment truments encompassing the major domains of riatric assessment makes the process of assessment nsiderably easier to perform and teach, and certainly re reliable. In addition, these instruments facilitate nsmission of understandable clinical information ween health providers, permitting smooth team- rk to occur, meaningful and valid data to be ulated, and therapeutic progress to be measured r time.

The recent book on assessing the elderly by Robert d Rosalie Kane provides an excellent analysis on the sting geriatric assessment instruments, and de- ibes in detail which are best for each particular ting and patient population.[3] In our experience, the st important assessment instruments, providing a not ordinarily obtained on the standard medical tory and physical examination, are those instru- nts in the areas of psychologic functioning (a gnitive function screen and a screen for depression) d overall functional status (a scale for measuring ivitites of daily living—ADL).

RIATRIC ASSESSMENT UNITS

Most geriatricians firmly are convinced that iatric assessment programs are effective in improv- both the process and outcome of geriatric care, n though well-designed studies clearly leading to s conclusion only now are beginning to appear. The ny published reports on geriatric assessment units Us) all show clear associations between the pro- ms and major improvements in care outcomes, ugh these reports have been based only on descrip- or quasiexperimental studies. Among these re- ted improvements from GAUs, summarized in le 3, are improved diagnostic accuracy, placement ation, functional status, and use of medications.[4] he first report to describe the success of a program he United States was published in 1973 on data n T. Franklin Williams's outpatient assessment program in Monroe County, New York.[5] Williams's pioneering program assessed all patients referred for nursing home placement in the county in an attempt to insure the appropriateness of these placements and to decrease unnecessary use of long-term care facilities. They found that only 38 percent of patients referred for nursing home placement actually needed such skilled nursing care, while 23 percent of the patients were able to return to their homes and 39 percent were able to go to board and care facilities or retirement homes following careful assessment and recommendations for specific therapy. Expert judgments made by an independent team of observers as to the appropriateness of placement locations before and after the initiation of the Monroe County program indicated that major improvements in placement decisions were being made—from 50 to 60 percent appropriate before to 84 percent appropriate afterward.[5] Several others have reported similar improvements in placement locations associated with assessments on GAUs, including our group at the Sepulveda VA, who showed improvement in placement location by over 50 percent of patients going through the GAU, based on judgments by the referring physician.[6]

Several reports have examined patients' functional status before and after treatment on those GAUs which include rehabilitation along with the assessment. These reports usually have used a validated measure of functional status, such as the Katz Index of Activities of Daily Living (ADL) to document change-over time.[7] They uniformly show that many patients improve during their stays on the GAUs. (Our paper from the Sepulveda VA reported improved functional status

TABLE 2

Measurable Dimensions in Geriatric Assessment

Physical health	
	Diagnoses/conditions present
	Physiologic severity indicators
	Quantification of medical services used
	Self-ratings of health or disability
Functional ability	
	Activities of daily living (ADL) scales
	Instrumental ADL scales
Psychological health	
	Cognitive function (mental status)
	Affective function
Social parameters	
	Social interaction network
	Social support needs and resources

TABLE 3

Improved Patient Outcomes Which Can Derive from Geriatric Assessment Programs

- Improved diagnostic accuracy
- More appropriate placement
- Less dependency on skilled nursing facilities
- Improved functional status
- More appropriate use of medications
- Better coordinated use of available community support services
- Improved emotional status and sense of well being

in over two-thirds of patients.[6]) However, the lack of control groups in most of the reports prevent a skeptical reader from concluding that the improvement came clearly from the GAU, rather than from the effect of time.

Another major area of GAU impact is the improvement in diagnostic accuracy, usually indicated by the diagnosis of new, treatable problems. Many have found large numbers of previously undiagnosed problems resulting from careful GAU assessment. Depending on each study's criteria for considering newly documented problems as new diagnoses (some only counted major new treatable problems), new diagnoses were found in frequencies varying from 0.76 per patient to almost 4 per patient. Most of these new diagnoses seemed to stem from an awareness that elderly patients need a more thorough search for treatable problems, although they also might reflect a lack of diagnostic thoroughness in the referring services.

Improvement in quality of treatment is difficult to quantify. One measurable parameter, use of prescription drugs, was examined in several programs. In those programs, drug prescribing generally was made more appropriate and usually was decreased in quantity, despite a concurrent increase in the number of diagnoses identified. (Our GAU paper reported over a one-third reduction of prescribed drugs).[6]

Two recent controlled studies have begun to confirm these descriptive reports. They also show that control group patients who survive the initial hospitalization also tend to improve in functional status over time, though not as much as those on the experimental unit. This indicates that not all the functional status improvement described earlier can be attributed to the GAU itself. Nonetheless the benefits from GAUs, at least to certain subgroups of elderly patients, are becoming more and more evident.

Lefton and Frengley published data from a retrospective case control study on their inpatient GAU at a rehabilitation hospital.[8] In their study, 50 consecutive patients aged 70 and over discharged from their GAU were compared retrospectively with 50 control patients discharged from other medical wards in the same facility, matched for age, sex, and primary diagnosis. Mean length of stay for patients in the two groups were comparable and fairly long (68.0 and 70.7 days, respectively), but reflected the extensive rehabilitation being performed along with the assessment. Discharge location significantly was better for the GAU group than for the control group (80 percent versus 62 percent were discharged to home settings, and 20 percent versus 38 percent to nursing homes, respectively). Patients in the GAU were more likely than control patients to improve their functional status (Katz ADLs, independent ambulation, and continence status) during their hospitalizations. At followup evaluations, performed several months after discharge, the living locations had not changed substantially, and significantly more GAU than control patients were still at home. However, functional status of control patients had improved at followup so as to approach the levels of the GAU patients.[8]

Our group at the Sepulveda VA Geriatric Assessment Unit has been conducting a prospective randomized experiment, comparing outcomes of frail elderly inp tients randomly assigned to enter the GAU or to co tinue receiving care on their acute hospital wards. Th study still is in progress, but preliminary data indica significant reductions in both one-year mortality ar overall use of institutional services by GAU patients a compared to control patients. In fact, the savings i direct medical care costs for the GAU group appear t be substantial and more than enough to pay for th program.

One important goal should be to identify which sul group of patients can be expected to benefit partic larly from the programs in order to make maximal us of scarce resources. While it might be argued that th majority of elderly probably could benefit from caref assessment, the bulk of older people generally a healthy, and the relative yield of assessment tends t be lower for healthy than for frail or ill elderly. In ge eral, those individuals most likely to benefit fro assessment are those who are on the verge of needin institutionalization, who are in the lower socioec nomic groups, who have inadequate primary medic care, and who have poor social support network These at-risk elderly seem to derive especially gre benefits from assessment and associated therapeut interventions.

SUMMARY

There is growing evidence that geriatric assessmen programs can be effective in improving health car outcomes for subgroups of frail elderly patients. Th improvements include better diagnoses, lower rates o nursing home placement, decreased medications, an improved functional status. Moreover, recently emerg ing controlled studies are showing improvements i survival and lower medical care costs in particula settings. Such programs need not follow a rigid mode but rather can be adapted to many different kinds o settings, both inpatient and outpatient, public secto and private. If some care is taken to target these ser vices to those particularly in need, then their prolifera tion is likely to fill a major gap in health care deliver for the elderly.

REFERENCES

1. United States General Accounting Office Report: Cos implications for Medicaid and the elderly. United States Gen eral Accounting Office, Washington, D.C., 1979.

2. Brocklehurst JC: Great Britain, in Brocklehurst JC (ed) *Geriatric Care in Advanced Societies*. Baltimore, MD, Univer sity Park Press, 1975.

3. Kane RA, Kane RL: *Assessing the Elderly: A Practica Guide*. Lexington, MA, D.C. Heath, 1981.

4. Rubenstein LZ, Rhee L, Kane RL: The role of geriatri assessment units in caring for the elderly: An analytic review *J Gerontol* 37:513-521, 1982.

5. Williams TF, Hill JF, Fairbank ME, et al.: Appropriat placement of the chronically ill and aged: A successful ap proach by evaluation. *JAMA* 226:1332-1335, 1973.

6. Rubenstein LZ, Abrass IB, Kane RL: Improved care fo patients on a new geriatric evaluation unit. *J Am Geriatr So* 29:531-536, 1981.

7. Katz S, Downs TD, Cash HR, et al.: Progress in the de velopment of the index of ADL. *Gerontologist* 10:20-30, 1970

8. Lefton E, Bonnstelle S, Frengley JD: Success with an inpatient geriatric unit: A controlled study of outcome and followup. *J Am Geriatr Soc* 31:149-155, 1983.

Geriatric Imperative: The Acutely Ill Elderly

Lucille A. Joel, ed.d., newark*

New skill levels of nursing manpower are needed for acute care of the aged, as well as a philosophy of care which if put into place would do much to avoid the profound regression which is so common when the elderly face episodes of illness.

The face of hospital nursing is changing. The combination of governmental strategies to urtail costs through reimbursement methodology nd the visible graying of America create a new clinical nvironment in acute care. Real pressure exists to in- titute aggressive treatment programs and speed dis- harge. The irony of the situation is that aggressive cute care management in its usual sense often is nappropriate to the clinical population being en- ountered in the 1980s.

Between 40 and 60 percent of acute care admissions nvolve patients over the age of 65.[1] Acute illness is a ery real part of aging, and provider professionals have een slow to admit that both the approach to treat- ient and the measures of success may markedly differ rom that which is appropriate to the younger patient. he aged are a clinical population beset by problems f chronic illness. The aged do die from heart attacks, ut usually they represent an acute exacerbation of an nderlying chronic condition. The elderly are victims f a slow and insidious onset of illness and frequent engthy periods of disability. Regardless of the skill of nedical management, cure usually is not possible. The icture of chronic illness as a central element in acute are of the aged is confounded by normal changes in he elderly which demand a greater investment in their are. Slowness becomes a way of life due to decreased hysical ability and diminishing acuity of the senses. Research tells us that it takes 15 percent more time to deliver nursing care to those over 65.[1]

The secret to successful acute care of the aged is provider professionals with special preparation and sensitivities to deal with the aged; a therapeutic regimen tailored to the needs of this group; environmental adjustments which make independence possible; and maximum suspension of institutional policies and routines where they interfere with the patient's normally effective way of doing things. Each of these topics deserve thorough exploration beyond the scope of this paper. Instead the author will aim to raise the reader's consciousness, and to hope to call to action some zealots who are ready to make a commitment to the aged.

Health care professionals have not been turned on to careers with the aged. The emotional high of therapeutic responsiveness and return to wellness is absent. Recovery, if possible, is fraught with slow progress and temporary cures. Though one can accept this clinical picture in long-term care, we have chosen to deny what is becoming reality in hospitals. This denial may be a protective mechanism to mask our own insecurity. Professional providers of all types have been ill-equipped to deal with the acutely ill aged. We have been slow in realizing that they are different, and not just

*Dr. Joel is Director, Teaching Nursing Home Project, Rutgers College of Nursing, Newark.

older adults. The goal of confinement may be to redefine a level of wellness with patients and help them adjust to it, rather than returning to a previous state of wellness. Such expectations demand a tedious interpersonal investment. It is premature to say that this role does not hold career interest for large numbers of nurses. Academic nursing has been slow in incorporating content and experiences specific to care of the aged into the curriculum. We are apt to be afraid of what we do not understand. Our poverty of understanding about the aged has blinded us to the challenges of gerontological nursing. A recent study in New Jersey documents patterns of investing fewer nursing resources in the care of the hospitalized elderly than was true for younger patients. The amount of nursing time allocated to a patient was related inversely to the age of the patient. The younger the patient, the greater the amount of time devoted to their care.[2]

Creativity in the use of support systems, activities, and meals will contribute to the total therapeutic effect.

Professionals who recognize care of the aged as a specialty, and possess the requisite knowledge, skills, and attitudes are the key to clinical success. Nursing has begun to address this challenge. Academic nursing has pioneered programs for primary health care providers to serve the aged and for tertiary providers or nurse gerontologists whose practice is characterized by a narrower scope, but more depth in select areas of clinical management. It already has been noted that our accomplishments have been less enviable in entry level nursing programs. Experiences with the aged should be as much of a clinical requirement as experiences with children or the childbearing family or the nonaged adult. Faculty should be encouraged to pursue researchable questions in gerontology and to focus their own practice in care of the aged.

Given the calibre of specialists suited to provide clinical direction, these individuals must be put in positions of authority. Caring for the elderly requires consistency and sophisticated clinical judgment as close to the bedside as possible. Delays in problem identification and therapy can create setbacks which may become difficult to recoup. For many of the elderly, wellness is dependent on maintaining a very delicate balance. They have no energies in reserve to cope with the demands of an acute episode of illness or to accommodate, for even a limited time, to the changes that come with hospitalization. The vulnerability of the elderly becomes painfully apparent as well-meaning health care professionals provoke regression and diminish once-adequate coping behaviors. All too frequently, a domino effect is set in motion. Strain on one system stresses another which is fragile, and so on. Limiting mobility may make incidents of incontinence difficult to avoid, and this may severely impact on self-esteem, which may promote social isolation. From there, it is a short step to confusion, disorientati and additional unacceptable behavior. The re tionships are obvious. It is not unusual for the ag to enter acute care institutions functionally able cope with community living and become dispositi problems during the course of their confinement. T patient role has been touted to promote dependen Additional social biases expect less from the elde and create the natural tendency to infantalize the Clinical management requires predictions about t level of self-care the patient can hope to attain, a more than valiant attempts to maintain the function ability they brought to the episode of illness. It b comes a serious issue with strong ethical overtones decide to intervene in a supportive manner and all decline. Maintaining the person's strengths som times may assume greater priority than resolution the acute problem.

Patients need to maintain control over their liv and daily living experiences. The comfort of bei "taken care of" is a luxury the aged can ill affo prematurely. A respite from the demands of life ca cause permanent decreased ability. In the best of sit ations, environment and routine should be adjusted allow for full participation in living. Although th analogy is distasteful, many of the same environment enrichments that have proved therapeutic for childre might be employed with this population. Furnitur toileting, and hygienic equipment should be placed proper heights. Color-coded doors or pathways ca mark the route to activity areas. Special space to kee personal effects personalizes the environment an helps with identity maintenance. Readily availab clocks, calendars, and other reminders of time an place increase orientation. Large print books an newspapers provide diversion, reality orientation, an stave off the temptation to become too self-centere One's normal patterns of living should be fostered, an networks should be established to maintain ties to th community. Environmental enrichments and institu tional policy adjustments are limited only by the exter of our own creativity.

The configuration of a therapeutic program for th acutely ill aged and the unique qualifications neede to work in this environment justify special care unit for these patients. The best manpower mix woul provide for primary health care nurses who are respon sible for clinical care on an ongoing basis. Their acute ly developed skills of observation would allow immedi ate intervention with subtle problems both related an unrelated to the primary condition which precipitate the hospitalization. Additionally, there is need fo clinical specialists in the areas of psychogerontology restoration, and perhaps even additional specialt areas, should the volume and case mix warrant. Ad vanced skill in cardiovascular nursing, rheumatology and pulmonary care may prove to be cost efficient. I these days of emphasis on curtailing costs in acut care, and reimbursement on a case mix basis, comple patients with an extended length of stay generate par ticular attention. Many of these individuals are aged Sophisticated nursing can decrease the length of stay minimize the number of disposition problems, an increase the functional capacity of the elderly so the can return to community living. Specialists in care o

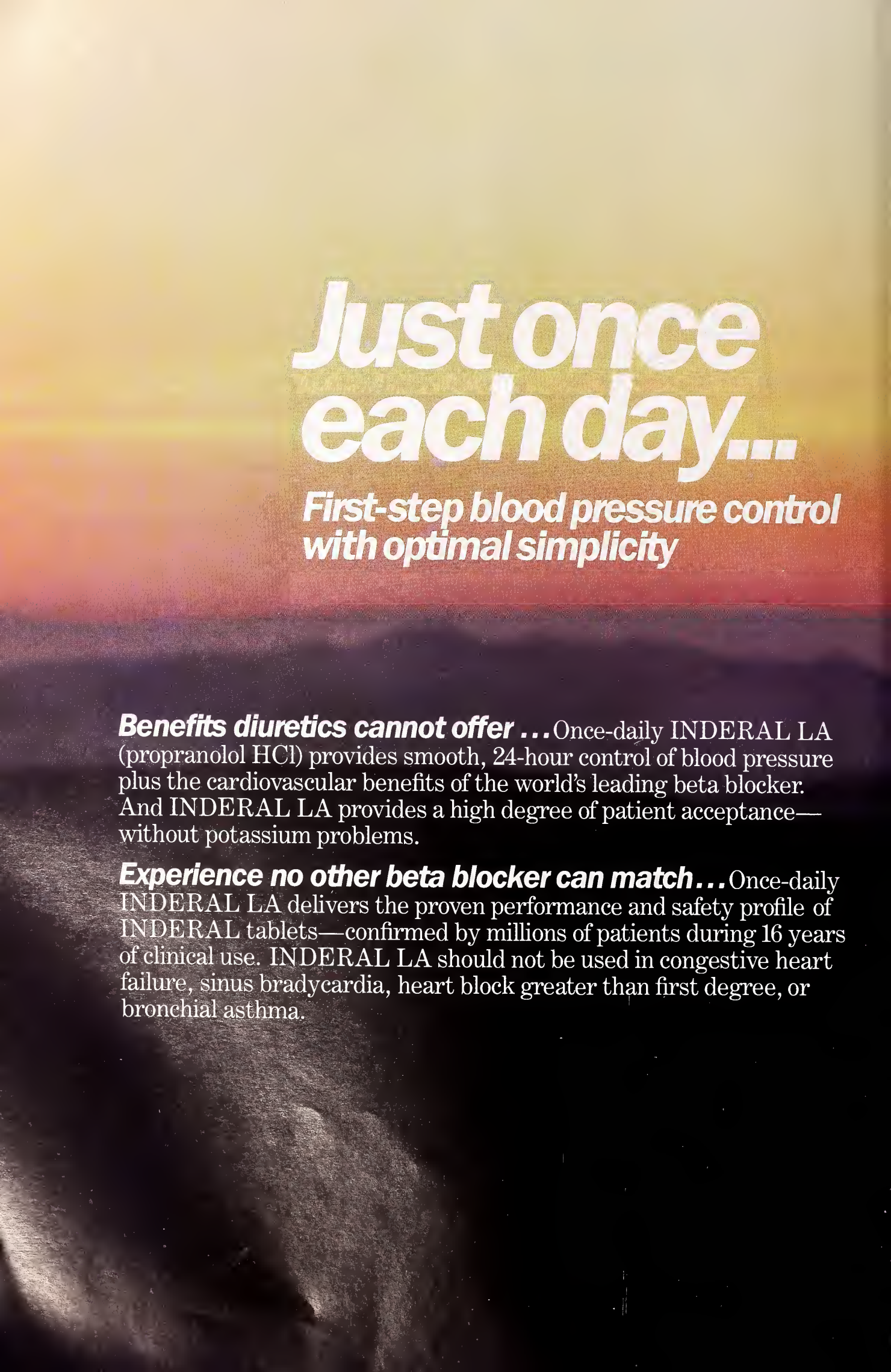
aged also can serve in a liaison capacity to other ts in the hospital who find they are servicing in- asing numbers of aged.

MMARY

ged persons in acute care hospitals deserve a ical program and provider professionals who will tribute maximally to their recovery. An entirely dif- nt mentality is called for in caring for the aged. intenance of functional ability and decision-mak- prerogatives become essential to life. Mechanisms st be put into place to avoid the profound re- ssion which can accompany an acute episode of ess. Maintenance of physical, mental, and emo- nal ability in all their dimensions become priorities. atever patterns were adequate and normal for the ividual prior to admission should be maintained. is may mean divorcing ourselves from every preconception of hospital routine. Creativity in the use of support systems, hygiene activities, meals, and sleep-rest patterns will all contribute to the total therapeutic effect. At all costs, life must be allowed to go on as usual. Exquisite nursing assessment must allow us to determine whether the patient should be cared for within a model that aims to develop new self-care ability, maintain what exists, restore to a previous level of functioning, or support what ability remains and accept inevitable decline. These decisions become very difficult and hold ethical consequences. They should be vested with the most sophisticated clinicians.

REFERENCES

1. Carr C, Mezey M: Giving the hospitalized elderly the best nursing care possible. *Health Services Manager* 104, 1982.
2. State of New Jersey, Department of Health: *Case Mix Nursing Performance Study.* Trenton, NJ, 1979.



Benefits diuretics cannot offer . . . Once-daily INDERAL LA (propranolol HCl) provides smooth, 24-hour control of blood pressure plus the cardiovascular benefits of the world's leading beta blocker. And INDERAL LA provides a high degree of patient acceptance—without potassium problems.

Experience no other beta blocker can match . . . Once-daily INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.



Start with 80 mg once daily... Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



80 mg 120 mg 160 mg

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

Just once each day for initial therapy in hypertension.

Ayerst®

Just once each day for initial therapy in HYPERTENSION.

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking th prior to major surgery is controversial. It should be noted, however, that the impaired at the heart to respond to reflex adrenergic stimuli may augment the risks of general anes and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of receptor agonists and its effects can be reversed by administration of such agents dobutamine or isoproterenol. However, such patients may be subject to protracted hypotension. Difficulty in starting and maintaining the heartbeat has also been reporte beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent th pearance of certain premonitory signs and symptoms (pulse rate and pressure chang acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyro Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symp of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have reported in which, after propranolol, the tachycardia was replaced by a severe bradyc requiring a demand pacemaker. In one case this resulted after an initial dose of propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with imp hepatic or renal function. INDERAL is not indicated for the treatment of hyperte emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Pa should be told that INDERAL may interfere with the glaucoma screening test. Withdrawa lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart dis elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as pine should be closely observed if INDERAL is administered. The added catechola blocking action may produce an excessive reduction of resting sympathetic nervous a which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or ortho hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals been conducted to evaluate toxic effects and carcinogenic potential. In 18-month stud both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of signi drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dc levels. Reproductive studies in animals did not show any impairment of fertility that attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryoto animal studies at doses about 10 times greater than the maximum recommended human There are no adequate and well-controlled studies in pregnant women. INDERAL sl be used during pregnancy only if the potential benefit justifies the potential risk to the

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised INDERAL is administered to a nursing woman.

Pediatric Use. Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; h tension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insor lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; disturbances; hallucinations; an acute reversible syndrome characterized by disorientati time and place, short-term memory loss, emotional lability, slightly clouded sensorium decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diar constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with ac and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytop purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male i tence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reac involving the skin, serous membranes and conjunctivae reported for a beta blocker (prac have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride sustained-release capsule for administration once daily. If patients are switched from INDE tablets to INDERAL LA capsules, care should be taken to assure that the desired therap effect is maintained. INDERAL LA should not be considered a simple mg for mg substitu INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration be necessary especially to maintain effectiveness at the end of the 24-hour dosing inte

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 8 INDERAL LA once daily, whether used alone or added to a diuretic. The dosage ma increased to 120 mg once daily or higher until adequate blood-pressure control is achie The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage o mg may be required. The time needed for full hypertensive response to a given dosa variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERA once daily, dosage should be gradually increased at three to seven day intervals until opti response is obtained. Although individual patients may respond at any dosage level average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few w (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERA once daily. The usual effective dose range is 160-240 mg once daily. The dosage ma increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response i obtained within four to six weeks after reaching the maximum dose, INDERAL LA the should be discontinued. It may be advisable to withdraw the drug gradually over a peri several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily
PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laborat

8950/

Ayerst® AYERST LABORATORIES
New York, N.Y. 10017

ERIATRIC IMPERATIVE: SUMMARY TATEMENT OF ACP STUDY GROUP

MICHAEL A. NEVINS, M.D., STEWART ALEXANDER, M.D., FRANCIS CHINARD, M.D., DWARD HARRIS, M.D., MARVEN WALLEN, M.D., WOODCLIFF LAKE*

Community hospitals now should initiate positive actions to respond to the geriatric imperative. This workshop of the New Jersey Chapter of the American College of Physicians offers five guidelines for implementing a fresh approach to hospital geriatrics.

The material collected at the workshop of the American College of Physicians-New Jersey apter (ACP) was sufficiently compelling to warrant e conclusion that community hospitals now should titate positive actions to respond to the geriatric perative. It is inappropriate to make broad genalizations about the quality of contemporary hospi- geriatrics in this country. Yet, although the current stem is satisfactory or improving in many respects, ere is room for improvement.

The following generic comments are offered as guides for implementing a fresh approach to hospital riatrics:

• Old age is neither a diagnosis nor a prognosis. ereotyping and labeling should be avoided. Many tients of advanced age are independent, capable of rticipating in the decision-making process referable their care, and require no different treatment than unger people. With advancing age, however, chronic sabilities of sensation, mentation, continence, and it increase substantially. Ward staffing and policy ould reflect this fact. Ideally, there should be a match tween patients' needs and the level of service dered; however, hospitals share with the health sysn in general a lack of sufficient alternatives to avoid equent mismatches.

• Care of the elderly should be oriented toward illss and global function rather than to specific diseases. Thus, diagnostic tests should be pursued only if they are likely to improve function or effect treatment. While hospitals are good at curing disease, they often pay too little attention to curing the patient. In parallel to treating the admitting disorder, there should be an overall assessment and early efforts should be made to prevent functional deterioration.

• The nature of hospital geriatrics programs will vary according to the special needs of individual institutions, but the concept of discrete geriatrics units has been amply tested and validated and has become normative in many countries. Such units can provide an efficient mechanism of clustering of staff and equipment as well as a means of expediting of specific policy. They should not be warehouses for elderly patients suffering from terminal illness or a condition from which reasonable rehabilitation is unlikely. The "success" of geriatrics units depends substantially on criteria for admission and whether the unit receives patients from the onset of hospitalization or after the acute illness has been corrected. Success depends also upon the enthusiasm and morale of the staff. The team concept is laudatory, but not easily accomplished and much effort must be expended to assure the staff's professional satisfaction.

*These five physicians are the Study Group of the American College of Physicians; the Study Group met at a workshop at MSNJ headquarters in May 1983.

• The hospital is the natural focal point for all community health services directed to the elderly. A continuum of care must be provided so that short-term gains are not wasted and community services coordinated so as to keep patients at home and delay or avoid institutionalization whenever possible. Also, it is necessary to develop a closer articulation between acute hospitals and long-term facilities. For example, initiatives might be made to address the problem of professional isolation of nursing home staff; hospitals could take the lead via educational and consultative outreach programs.

• The 1980s will be an era of stress for health institutions, but rather than becoming despondent because of limited resources, hospitals should respond to the challenge and re-evaluate traditional policies.[1] Many of the changes necessary for excellent geriatric care involve altered thinking and attitudes rather than costly new equipment.

Finally, this study group endorses the ten standards for good health care for the aged proposed by the Scottish geriatrician D.C. Kennie,[2] namely:

1. Emphasis on the restoration of functional abil
2. Building and maintaining a support system.
3. Broadened approach to health assessment.
4. Application of specific medical knowledge a skills.
5. Cautious medical intervention.
6. True advocacy for the patient.
7. Acceptance of the legitimacy of death.
8. Increased community orientation.
9. Allowance of sufficient time for recovery.
10. Continuity of care.

REFERENCES

1. Blendon RJ, Schramm CJ, Moloney TW, Rogers DE: era of stress for health institutions. *JAMA* 245:1843-1 1981.

2. Kennie DC: Good health care for the aged. *JA* 249:770-773, 1983.

PHARMACOLOGICAL BASIS OF THERAPEUTICS: GOSSYPOL, AN ORAL MALE CONTRACEPTIVE?*

STEPHEN M. PENNINGROTH, PH.D., PISCATAWAY**

Gossypol acts by inhibiting spermatogenesis, in particular by impairing the motility of sperm. Its antispermatogenic effect is reversible in many cases. Gossypol shows systemic toxicity at high doses. More study is required before gossypol can be approved for general use as an oral male contraceptive.

Women may choose among a variety of contraceptive strategies including pharmacologic methods (estrogen/progestin combinations, vaginal spermicides, prostaglandins as abortifacients), a mechanical barrier to conception (diaphragm), or surgical sterilization. While a mechanical method (the condom) and surgical sterilization (vasectomy) are available to men, pharmacological contraceptive strategies conspicuously are lacking. This dearth of antifertility drugs for men springs from continuing ignorance of many aspects of the cellular and molecular basis of male reproductive physiology. It is interesting to speculate on the historical and cultural currents that have fostered intensive investigation of reproduction in women and comparative neglect of reproduction in men; however, this would lead far afield.

Chemical contraceptives for men can be divided into two general classes: 1) agents designed to inhibit spermatogenesis by interfering with its endocrine control (androgens, estrogens, or progestins)—a major drawback is that by inhibiting testosterone synthesis they suppress libido and potency; 2) agents which block spermatogenesis or the maturation of sperm in the epididymis—a major disadvantage is their toxicity.[1] A basic requirement for any male contraceptive is virtual total efficacy in blocking sperm function, since survival of only a small number of the hundreds of millions of sperm cells in the average ejaculate may suffice for fertilization.

During the past decade, testing of an oral contraceptive for men, gossypol, has begun. This article summarizes current knowledge of the efficacy, toxicity, and mechanism of antifertility action of this potential new male contraceptive.

ISOLATE OF THE COTTON PLANT

Gossypol, a yellowish polyphenolic compound isolated from the seeds, stem, and root of the cotton plant, is known to be toxic at high doses. It is the principal reason that cottonseed cake has not been developed as a cheap protein source.[2] Its male contraceptive effect was discovered accidentally when Chinese toxicologists investigated the cause of low

*This article, fourth in a series, prepared under the leadership of Bruce McL. Breckenridge, M.D., Chairman, Department of Pharmacology, UMDNJ-Rutgers Medical School, is a brief review of recent advances in pharmacology and related preclinical sciences which will help readers to understand the actions of new and established therapeutic agents. The reviews do not consider indications for specific drugs, incompatabilities, or dosage forms, which can be found in the *AMA Drug Evaluations, 5th Edition*, 1983.

**Dr. Penningroth is an Assistant Professor, Department of Pharmacology, UMDNJ-School of Osteopathic Medicine, Piscataway. Correspondence may be addressed to Dr. Breckenridge, UMDNJ-Rutgers Medical School, P.O. Box 101, Piscataway, NJ 08854.

fertility in a region of China where crude cottonseed oil was used extensively in cooking. In 1978, the National Coordinating Group on Male Antifertility Agents (Peoples' Republic of China) published the first indepth study of the pharmacologic action and toxicity of gossypol.[3]

TRIAL RESULTS FROM CHINA

Gossypol, 20 mg/day, was given to 4,000 healthy men for periods of six months to four years. Infertility was achieved in 99.89 percent of the subjects within two months as judged by semen analysis demonstrating necrospermia or a sperm count below 4 x 10^6 sperm/ml. The proportion of motile sperm decreased and the proportion of malformed sperm increased progressively with gossypol treatment. Exfoliated mono-, bi-, and multinucleated spermatocytes and spermatids also were seen. Examination of damaged sperm cells in the electron microscope revealed disruption of the mitochondrial sheath, derangement of the coarse axial fibers, and depletion of the acrosome. With time, azoospermia ensued. When gossypol was discontinued, the number and morphology of sperm returned to normal within three months, indicating reversibility. Side effects were minimal: transient weakness at the start of drug administration which subsided without treatment (12.8 percent), and loss of libido but not potency (6 percent); recovery followed symptomatic treatment without discontinuing gossypol, suggesting a psychological reason for decreased libido. Levels of serum testosterone and leuteinzing hormone (LH) were normal. Hypokalemia was noted among subjects in certain districts. However, hypokalemia is a general medical problem in China today;[21] thus the link between gossypol and hypokalemia is tenuous. Pharmacokinetic data from studies with rats indicated gossypol is distributed principally in the liver, spleen, lung, blood, kidney, and heart; significantly lower concentrations are found in the testis, indicating the antispermatogenic action of gossypol is testis-specific.

The discovery that gossypol inhibits spermatogenesis in men with minimal side effects offers the possibility of an oral contraceptive.

The findings reported by Chinese scientists subsequently have been confirmed in their major aspects and expanded. The absence of LH and testosterone effects has been noted repeatedly,[4,5] however, one study suggests gossypol inhibits testosterone synthesis in isolated interstitial cells.[6] The apparent lack of mutagenicity of gossypol has been confirmed.[7,8] Recent studies have indicated that gossypol may have a beneficial hypolipidemic effect,[9] and that also it inhibits catechol-O-methyltransferase, a major enzyme in catecholamine catabolism. This may prove to be a troublesome side effect in view of the high concentration of gossypol attained in some tissues.[10]

MECHANISM OF ACTION

The mechanism of action of gossypol currentl under investigation in several laboratories. functional parameter most sensitive to goss appears to be sperm motility.[11-14] The first anatc lesion that is observed by electron microscopy segmental aplasia of the mitochondrial sheath of sperm tail.[11] This lesion does not occur until lat spermiogenesis (step 18).[12,13] It apparently induces dislocation of axial fibers observed in epididy sperm. The damage to the acrosome reported Chinese workers has not been confirmed in s sequent studies.[11,12] The seminiferous epithel shows some damage consisting mainly of vacuola of Sertoli cells; however, this effect is highly focal volving less than 50 percent of the germinal thelium. Interstitial (Leydig) cells are not affecte gossypol.[12]

Possible molecular bases for the observed lesion sperm are enzymes that may be crucial to sperm differentiation. A sperm-specific isozyme of lac dehydrogenase, LDH-X, as well as acrosin, a prote found in the acrosome, are inhibited by gossypo vitro.[15,16] Gossypol also is known to uncouple oxida phosphorylation.[14] However, the relationship of th enzyme inhibitory effects to the antispermatoge action of gossypol is not clear. Sperm flagellar (dyn ATPase activity, which is crucial to motility, is significantly inhibited.[14] Finally, gossypol has b shown to decrease testis weight in an animal mo suggesting it may have an antiandrogenic effe Hovering over all studies of gossypol mechanism is question of the possible role of gossypol metabolite Two interesting effects of gossypol have been repo which do not appear to be related to antispermatogenic effect. Thus, gossypol inhibits growth in culture of herpes simplex virus typ (responsible for genital herpes)[18] and of *Trypanoso cruzi* (responsible for Chagas's disease).[19]

CONCLUSION

The discovery that gossypol effectively inhib spermatogenesis in men with minimal side effe offers the real possibility of an oral male contracept However, the effects of gossypol may not be reversi in all cases.[20] Further, gossypol is known to be tc at elevated doses. Thus, its therapeutic index may quite narrow. The mechanism of action and poten toxicities of gossypol must be understood better bef it can be approved as a safe contraceptive strategy men. A welcome spinoff of further gossypol resea may be the stimulation of greater interest understanding the molecular and cellular basis of m fertility.

REFERENCES

1. de Kretser DM: Towards a pill for men. *Proc R Soc L B* 195:161, 1976.
2. Lawrence SV: Gossypol: A potential male contracepti *Am Pharm* 21:57, 1981.
3. National Coordinating Group on Male Anifertil Agents: Gossypol—a new antifertility agent for males. *C Med J* 4:417, 1978.
4. Shandilya L, Clarkson TB, Adams MR, Lewis JC: Effe of gossypol on male cynomolgus monkeys *(Mac fascicularis). Biol Reprod* 27:241, 1982.

5. Hoshai H, Uehara S, Mori R, Nagaike F, Tsuiki A, Suzuki
Gossypol as oral contraceptive for male: Trial case report.
hoku J Exp Med 138:275, 1982.
6. Lin T, Murono EP, Osterman J, Nankin HR, Coulson PB:
ssypol inhibits testicular steroidogenesis. *Fertil Steril*
:563, 1981.
7. de Peyster A, Wang YY: Gossypol-proposed contraceptive
men passes the Ames test. *N Engl J Med* 301:275, 1979.
8. Majumdar SK, Ingraham HJ, Prymowicz DA:
ssypol—an effective male contraceptive was not mutagenic
sperm head abnormality assay in mice. *Can J Genet Cytol*
:777, 1982.
9. Shandilya LN, Clarkson TB: Hypolipidemic effects of
ssypol in cynomolgus monkeys *(Macaca fascicularis).*
ids 17:285, 1982.
10. Tang F, Tsang AYF, Lee CP, Wong PYO: Inhibition of
techol-O-methyltransferase by gossypol: The effect of
sma proteins. *Contraception* 26:515, 1982.
11. Oko R, Hrudka F: Segmental aplasia of the
tochondrial sheath and sequelae induced by gossypol in
t spermatozoa. *Biol Reprod* 26:183, 1982.
12. Hoffer AP: Effects of gossypol on the seminiferous
ithelium in the rat: A light and electron microscope study.
Biol Reprod 28:1007, 1983.
13. Oko R, Hrudka F: Effect of gossypol on spermatozoa.
Arch Androl 9(1):39, 1982.
14. Tso WW, Lee CS, Tso MYW: Effect of gossypol on boar
spermatozoal adenosine triphosphate metabolism. *Arch
Androl* 9:319, 1982.
15. Lee CYG, Moon YS, Yuan JH, Chen AF: Enzyme
inactivation and inhibition by gossypol. *Mol Cell Biochem*
47:65, 1982.
16. Tso WW, Lee CS: Gossypol: An effective acrosin blocker.
Arch Androl 8:143, 1982.
17. Lee CY, Moon YS, Duleba A, Chan AF: The instability
of gossypol. *Arch Androl* 9(1):33, 1982.
18. Wichman K, Vaheri A, Juukkainen T: Inhibiting herpes
simplex virus type 2 infection in human epithelial cells by
gossypol, a potent spermicidal and contraceptive agent. *Am
J Obstet Gynecol* 142:593, 1982.
19. Montamat EE, Bungos C, de Bungos NMG, Roval LR,
Blanco A: Inhibitory action of gossypol on enzymes and
growth of Trypanosoma cruzi. *Science* 218:288, 1982.
20. Guo-Zhen L: Double-blind study of gossypol: The
loading phase. *Arch Androl* 9(1):38, 1982.
21. Bardin CW: Personal communication.



More people have survived cancer than now live in the City of Los Angeles.
We are winning.

Please support the

AMERICAN CANCER SOCIETY®

The Impaired Physicians Program: Another Kind of Impairment

Edward G. Reading, M.Div., Lawrenceville*

There are many kinds of impairment. The Impaired Physicians Program of the Medical Society of New Jersey is here for your use, so tap the resources of this special program.

Generally speaking, impairment among physicians is considered to exist when the physician is prevented from functioning at a professional level due to chemical use or dependency or problems with mental health or physical disability. While these are the primary categories of impairment dealt with by the Impaired Physicians Program, we now are able to identify another category of impairment which previously has been all but lost in a sea of confusion.

Physicians can be prevented from peak functioning when their minds are not on their work because of family members or "significant others" who are chemically dependent or who themselves have emotional or physical problems. One of the issues frequently recognized in the literature on addictionology is called the "family disease" of chemical dependency. This issue goes far beyond that of biological heredity. It is involved with the relationships which develop between a chemically dependent person and those who have an "emotional investment" in them. Most often these are family members. The Impaired Physicians Program has tried to emphasize the necessity of family members being in treatment with the physician who is chemically dependent.

CASE EXAMPLE 1

Dr. S is living with his family in an urban community with his wife and three children. The youngest child is 16 and has become involved in alcohol abuse, as well as suspected marijuana use. There are more frequent incidents of coming home intoxicated on weekday nights. Recently, when Mrs. S confronted the adolescent about the drinking and suspected other drug use, the 16 year old became violent and pushed her against the stove, scalding her with boiling water. Dr. and Mrs. S are not able to control the situation. The other two children are very successful in college. Dr. S treated his wife for the burns and has had to cancel patient appointments due to loss of sleep at night, appointments with school officials, and anxiety caused by the high degree of stress in the household. With his mind on the home front, he has not been as attuned to his patients' needs as he should be.

Recently, a parent came to him to seek advice on how to handle a similar problem with her child. He gave advice; advice which he was not accepting for himself. Now he feels guilty and embarrassed over his own situation. Dr. S is impaired. He needs assistance in dealing with his problem, for his own sake, his family, and his patients. He can use the assistance of the Impaired Physicians Program.

CASE EXAMPLE 2

Dr. J is a resident at a suburban hospital. She was

Rev. Reading is Assistant Director, Impaired Physicians Program, MSNJ.

called by the police in her mother's community and told that they picked up her 62-year-old mother walking aimlessly on the highway, unable to remember her name, where she was coming from, or where she was going. Dr. J, being an only child and single, decided to take her mother into her home to care for her. Dr. J constantly is being called at the hospital by her mother and by neighbors describing strange happenings around the house. Due to the influence these events have had on her job performance, she has had two warnings to "shape up or ship out."

Dr. J is impaired. She is not dealing effectively with her mother's disabling condition. She can use the assistance of the Impaired Physicians Program.

CASE EXAMPLE 3

Dr. C's wife is an adult child of two alcoholic parents who died when she was 15. She is a very insecure person who tries to be in control of the situation at all times. Mrs. C had a psychotic breakdown which caused her to be admitted to a psychiatric hospital. The C's children "blame" Dr. C for causing the breakdown. Dr. C is not able to function effectively in his practice. He is impaired. He needs help in dealing with his situation at home. He can use the Impaired Physicians Program.

CASE EXAMPLE 4

John is a third-year medical student. His father is an alcoholic lawyer who is in danger of losing his practice, as well as his family and friends. John has h to leave school periodically to return home to "pick the pieces" after a drinking bout. John's mother is v embarrassed about "the neighbors finding out." Jo is missing so much class time that he is in danger being thrown out of school. The high degree of str that the family is experiencing is causing John begin some drug use of his own. John's father nee help, and so does John. This family can use the I paired Physicians Program.

CONCLUSION

The Family Services component of our Program c help the physicians in these situations. Additiona we can help families of chemically dependent phy cians get into their own recovery program. We c assist in helping physicians in our Program "talk their children" (if it is appropriate) about their o disease.

There are many kinds of impairment. There a many resources, frequently unknown to the impair physician and his family. For every type of impairme there is a way to effectively deal with it. It may difficult but it always is easier to deal with diffic situations with help from concerned, caring p fessionals, than to try to handle it alone.

If you are in such a situation, or know of a physici who is, please call (609) 896-1766 and tap the sources here for your use.

Your Congressman Speaks: The Cost of Health Care

Congressman Jim Courter*

There is a need to find reforms that can introduce competitive forces into the market for medical care without imposing excessive burdens on the individual or reducing the quality of care.

It is a great honor for me to accept The Academy of Medicine of New Jersey Citizen's Award r 1984. I am extremely gratified to receive your recogtion for the work that the people of my district have ected me to perform. The Academy of Medicine of New rsey also is deserving of recognition and praise, for e more than 70 years of work you have done to lvance the cause of quality health care for the people New Jersey.

I would like to take a few moments to discuss the sue of organ transplants before I get to the main pic of my talk. It has been several years now since rgeon-General Everett Koop, liver transplant ecialist Dr. Tom Starzl, and I got together to discuss e widespread use of organ transplant surgery and e mind-boggling implications of the immunity-supressing drug, cyclosporine A. Since that time, there as been a surge in public awareness of the great nefits of this surgical technique, and this publicity as helped save the lives of a number of young transant patients.

But, while science rapidly has improved the effectiveess of organ transplants, the nation's system for reieving organs has failed to keep pace. Advances in edical science have expanded transplant needs to clude several organs, yet a national procurement sysm exists only for kidneys. Of the 20,000 persons who ffer brain death that could result in organ donations ch year, fewer than 15 percent actually result in donations. This occurs despite a 1982 Gallup poll which showed that 72 percent of those persons surveyed said they would give permission to have certain organs of a loved one donated after death. To compound the problem, transplant surgery still is considered "experimental" by many health insurers. As a result, patients whose health plans won't cover organ transplants are denied the surgery because they cannot finance the large down payments required by hospitals.

In view of these problems, it gives me great pleasure to tell you that in the near future, the House of Representatives will consider the "National Organ Transplant Act." This comprehensive bill will improve retrievement through establishment of organ procurement organizations, as well as a U.S. Transplant Network to help distribution of organs nationwide. The bill also will help patients and their families with the expenses involved in transplant operations by requiring the U.S. Department of Health and Human Services to purchase and supply patients with the immunosuppressive drugs that are essential for successful transplants. This legislation should pave the way for even greater participation in transplantation by the medical profession and private medical insurers. I urge you to give the measure your attention and support.

*Congressman Jim Courter represents the 12th District of New Jersey and is a member of the Select Committee on Aging. This talk was presented at The Academy of Medicine of New Jersey Annual Dinner.

The main topic I would like to address tonight is the rising cost of health care, and some of the approaches being discussed in Washington to deal with this situation.

It cannot be denied that the cost of health care is increasing dramatically, and has continued to increase above the general rate of inflation in the economy. In 1965, 6 percent of our gross national product (GNP) was consumed by health care expenditures—in 1982, that figure was 10.5 percent of GNP. There has been a dramatic growth of the federal government's expenditure on health care. The combined cost of the Medicare and Medicaid programs, which was $3.9 billion in 1967, reached $64 billion in 1982, and is projected to reach $100 billion by 1986.

Before we consider measures that government might take to lessen this growth, we first must determine to what extent the rising cost of medical care is a problem that calls for a federal government solution. Certainly, a significant portion of the money we spend on health care has paid for new services and technologies which were not available a few years or a few decades ago.

You know this far better than I do—as you look around at your work environment, you see all kinds of new tools of the medical profession that have brought dramatic qualitative improvements to the menu of health care services available to the average American. The CAT scanner, burn units, coronary intensive care units, and shock-trauma centers are but a few examples of recent, high-technology improvements that have expanded your diagnostic and healing powers, and saved lives.

We all would prefer that new medical technologies would cost less, but there are few in our society who would argue that they are not worth having because they may be very expensive.

In fact, many of the reforms discussed during the 1970s such as national health insurance and hospital cost containment were defeated, for a very good reason: it was feared that these reforms would cut costs by rationing health care and reducing the availability of promising new methods of treatment.

So, before Washington sets out to save America from rising medical expenses, it should observe the great dictum: "If it isn't broke, don't fix it." There is nothing inherently wrong with paying more for a higher quality service. It would be a terrible mistake to reform the economics of medicine in a way that would reduce the quality of the greatest health care delivery system in the world.

However, there are steps that can be taken to control the cost of health care. To illustrate the type of reform I have in mind, I would like to use an example from a field where I do have some expertise—the field of defense.

I am sure you all have seen the press reports of exorbitant prices paid by the Department of Defense for simple goods and spare parts. This situation was discovered by the Pentagon's own auditors and investigators, and reforms are being made to prevent this kind of waste in the future. But how did this ever come about? How could anyone be so foolish as to pay $100 for a simple diode, or more than $690 for a 50-cent metal washer? The answer is simple. The consumer did not know what goods were being bought for wh price. Supply officers who authorized payment sa numbers on a computer screen—some represent prices, some represented symbols for the goods—a there was no warning, nor any incentive system, whi caused these discrepancies to be discovered. In oth words, the consumer was insulated from the cruc information he needed to make a sound jud ment—the information on the cost of the goods he w buying.

To a large degree, the consumer of health care America is in a similar situation—he is insulated fr the cost of the service he buys, because bills are pa by third parties, such as the government, the employ or the insurance company. The incentive to sh around and to compare prices and services largely absent in health care even though market incentiv serve us so well in every other sector of the econom

We need to find some reforms that can introdu competitive forces into the market for medical ca without imposing excessive burdens on individuals reducing the care available to the needy in our socie

While many of the Reagan Administration's a pointees were proponents of pro-competition reform in health care, a few years passed before the Admini tration put forward a set of actual legislative proposa to accomplish this goal. Now that these proposals a on the table, they deserve serious consideration ar discussion by all of us who have an interest in mai taining affordable, high-quality health care in Americ

One proposal would place a modest cap on the t exemption given to employer-financed health i surance. This cap would be designed to prevent th type of overinsurance which unnecessarily can dri up utilization rates and costs.

Another administration proposal would requi modest copayments by patients for Medicare rein bursements for inpatient hospital care. This would ad to the incentive for outpatient treatment and reduce hospital stays, and it would generate funds that cou pay for catastrophic coverage under Medicare.

A third proposal would create a Medicare vouch program to encourage consumers to save mone through more economical alternative private healt insurance programs.

Taken together, these proposals seek to reform th health care system by increasing consumer awarenes of medical costs and services. They are modest an responsible and they will provide incentives for r duced cost without depriving any member of societ of needed medical care. Above all, they are far superio to the proposals of previous administrations, whic would have increased government involvement an regulation and would have reduced the availability o quality medical care.

It is unfortunate, in my opinion, that Congress ha given these sound proposals so little attention sinc they were introduced. There is little prospect that Con gress will act on them this year, so we will have to wai until next year's session of Congress before any actio can be taken. When that time comes, I hope that thes proposals will receive the careful consideration an support of the medical profession.

NEW YORK FERTILITY RESEARCH FOUNDATION, INC.

r the Investigation of
Problems of Human Infertility

e Foundation provides a complete agnostic and consultation service for in-tile couples. Investigations are con-cted by well-known specialists in con-nction with consultants in the various lds of medicine related to infertility.

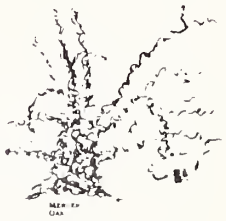
e Foundation is supported by an in-use modern laboratory equipped to do ost tests required for diagnosis and eatment. Literature on request.

1430 Second Avenue, Suite 103
New York, N.Y. 10021
Phone: (212) 744-5500

The Academy of Medicine of New Jersey

presents

Original Limited
Edition Print
Mercer Oak
by Richard Kemble, $40



For more information, call 896-1717

PUBLIC RELATIONS

for physicians and surgeons with a medical specialty. Please call for a confidential conversation with an experienced professional.

Seymour F. Malkin Public Relations
Phone 201-666-4400
651 Colonial Boulevard
Washington Township
Westwood P.O., New Jersey 07675

***The Journal* of the**
Medical Society of New Jersey
presents

300 YEARS OF MEDICINE IN NEW JERSEY

September 1984

We are celebrating the history of medicine in New Jersey. This special issue illuminates the beginnings of our health care system and the growth of medical care: essays highlight those talented individuals who devoted themselves to this system, and commentaries present the development of specialized care in associated fields of medicine. Plus a special photography section highlighting three statewide exhibits.

Copies of this issue are available by sending $5.00 (check or money order) to MSNJ, Two Princess Road, Lawrenceville, NJ 08648. All MSNJ members will receive one copy of this issue.

Name _____

Address _____

_____

Enclose a $5.00 check or money order for each copy.

UMDNJ Notes; MSNJ Auxiliary; New Members; Physicians Seeking Location in New Jersey

UMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

The University has been making major strides in two fields that concern the medical profession in New Jersey: cancer treatment and research, and biotechnology research.

The Center for Molecular Medicine and Immunology on our Newark campus, which officially was opened on June 13, is devoted exclusively to the use of monoclonal antibody "tracer bullets" to detect cancer. CMMI's president, David M. Goldenberg, Sc.D., M.D., is the vanguard of investigators using monoclonal antibodies to diagnose cancer earlier and more accurately and to locate cancer more accurately in the body. Patients have come long distances from within the country and from overseas for CMMI diagnosis.

CMMI has increased the clinical resources, scientific base, and reputation of the University's cancer programs, providing new opportunities for New Jersey patients and medical students, as well as to the cancer research and cancer care programs of the entire region. As Michael Bongiovanni, chairman of Squibb Medical Products, said at the CMMI dedication, no state is more dedicated to health education, research, and care than the state of New Jersey.

As part of that dedication, we recruited Dr. Goldenberg and his research team from the University of Kentucky more than a year ago. The present staff of 25 scientists and support personnel is expected to grow to 80. The opening of CMMI, which has initial funding of $3.45 million, symbolizes the start of an entirely new phase of New Jersey's battle against cancer.

On another front, biotechnology research, progress is being assisted by state grants totaling $717,800 for state-of-the-art equipment. Among equipment to be purchased are two DNA synthesizers, a cell-sorter, and nuclear magnetic resonance spectrometer (NMR). These devices are essential for the creation and production of new biomaterials that may be used for purposes ranging from cancer treatment to the destruction of toxic waste.

More than half of the money—$332,800—will be concentrated on buying equipment for the Center for Advanced Biotechnology and Medicine, whose establishment was a high priority recommendation of the Governor's Commission on Science and Technology, on which I serve.

Satellite facilities of the biotechnology center will include Middlesex General-University Hospital in New Brunswick, core teaching affiliate of UMDNJ-Rutgers Medical School, and the Waksman Institute of Microbiology, part of Rutgers University. Norman H. Edelman, M.D., associate dean for research at UMDNJ-Rutgers Medical School, earlier was named acting director of the center, which is to be administered jointly by UMDNJ and Rutgers University on the Piscataway campus.

UMDNJ-New Jersey Medical School in Newark received $75,000 from the state biotechnology grant total. That money will go toward purchasing a DNA synthesizer and computer analysis system for DNA studies directed by Giampiero di Mayorca, M.D., chairman of the department of microbiology. Additional funds are being sought to meet the total equipment cost of $131,000.

The line between unwarranted fear of environmental can dangers and exposures which co stitute a real threat is difficult the lay public to distinguish.

The Department of Environm tal and Community Medicine UMDNJ-Rutgers Medical School using a $75,000 grant from t Exxon Foundation to develop model program for getting the lat information on environmental a industrial chemicals to the pub Codirectors of the project Michael Gochfeld, M.D, Ph. clinical associate professor, a Audrey Gotsch, D.P.H., assist professor and director of the depa ment's Office of Consumer Hea Protection.

The University is a constan changing scene of new faces a new places to serve patient ca medical education, and resear Among recent changes are thes

John W. (Jack) Bingham, an perienced New Jersey hospital ministrator, has joined UMDNJ-U versity Hospital in Newark as ch operating officer. Jack came UMDNJ from the Hackensack Me cal Center, where he worked eig years and was senior vice-presid and director of hospital operatio Before that he was associate direc at the Jersey City Medical Cente

Stanley J. Robboy, M.D, an int nationally recognized patholog has accepted the appointment professor and chairman, depa ment of pathology, and UMDNJ-N Jersey Medical School. Dr. Robb who comes to us from the Harva Medical School faculty, is not among other accomplishments, research into DES, the synthe hormonal preparation linked cancer in women whose moth had taken it, and in the use of co puters in medical management a information systems.

The Cognitive Rehabilitation P gram of UMDNJ-Rutgers Medi School has been renamed T Center for Cognitive Rehabilitati and moved from the Piscataw campus to 97 Bayard St. in N Brunswick. Directed by Irwin Pollack, M.D., professor of psychia at UMDNJ-Rutgers Medical Sch the center offers therapy to peo who have suffered traumatic br injury from accident, infection, s gery, or stroke, and whose ability think and act in an orderly man has been damaged.

SNJ Auxiliary

ace Gellman
:sident

The 1984 to 1985 officers of the SNJ Auxiliary were installed by s. John Bates, AMA Auxiliary sident on May 5, 1984, during Annual Meeting at Resorts International, Atlantic City.

Chairmen have been appointed d the proposed program for the ning year will be presented to the dical Society of New Jersey for approval.

Your Auxiliary sent seven delates to the AMA Auxiliary Annual ssion. We were so proud to see our n Mrs. James Brennan installed treasurer of the AMA Auxiliary by past-president, Mrs. Harry Dvorsky. I was honored to be invited to be in the receiving line at the Medical Society of New Jersey's reception at the Chicago Marriott when Karl T. Franzoni, M.D., and Arthur Bernstein, M.D., were presented for AMA Councils on Medical Services and Scientific Affairs, respectively.

While in Chicago, Mrs. Charles Moloney and I had an opportunity to meet with John Moore, Assistant Professor of Communication Arts at Loyola University. He will present the annual Workshop Program of the MSNJ Auxiliary in Lawrenceville on September 24th. His subject is "Avenues Leading to Personal Success: Ingredients for Self-Assurance." All members of the Medical Society and the Auxiliary are encouraged to attend.

We had attended Professor Moore's seminar at last year's Leadership Confluence in Chicago and were impressed by his dynamic presentation. It was a real learning experience.

***The Journal* of the**
Medical Society of New Jersey

presents

300 YEARS OF MEDICINE IN NEW JERSEY

September 1984

We are celebrating the history of medicine in New Jersey. This special issue illuminates the beginnings of our health care system and the growth of medical care: essays highlight those talented individuals who devoted themselves to this system, and commentaries present the development of specialized care in associated fields of medicine. Plus a special photography section highlighting three statewide exhibits.

Copies of this issue are available by sending $5.00 (check or money order) to MSNJ, Two Princess Road, Lawrenceville, NJ 08648. All MSNJ members will receive one copy of this issue.

Name _____

Address _____

_____

Enclose a $5.00 check or money order for each copy.

New Members

The Journal would like to welcome the following new members to the Medical Society of New Jersey:

Atlantic County

Fernando J. Delasotta, M.D., Somers Point
Vithal D. Kardani, M.D., Atlantic City

Bergen County

Frank C. Arturi, M.D., Cliffside Park
Roger H. Coletti, M.D., Oakland
Lynda A. Farrell, M.D., Oakland
Sundararamaiah Ganti, M.D., Englewood
Digvijay S. Girnar, M.D., Hackensack
Robert M. Israel, M.D., Westwood
Donald Liss, M.D., Englewood
Howard Liss, M.D., Englewood
Gregory A. Pappas, M.D., Fort Lee
Almerindo G. Portfolio, Jr., M.D., Ridgewood
Donald C. Syracuse, M.D., Belleville
Morris A. Tilson, M.D., Fair Lawn
Drew E. Tuckman, M.D., Fair Lawn
Shirley Tung, M.D., Fort Lee
Kenneth H. Wasserman, M.D., Englewood
Joseph H. Willner, M.D., Englewood

Camden County

Shwu-Miin Yang Chen, M.D., Cincinnati, Ohio
Robert H. Gerard, M.D., Blackwood
Mark S. Isserman, M.D., Voorhees
Mark A. Macklis, M.D., Camden
William A. Morowitz, M.D., Blackwood
Andrew S. Olearchyk, M.D., Audubon
Lolita M. Ramos, M.D., Voorhees
Robert M. Williams, M.D., Bellmawr

Essex County

Terence J. Aherne, M.D., Roseland
Ricardo Alzadon, M.D., Irvington
Uma Ananthapadmanabha, M.D., Bloomfield
Ruby G. Bendersky, M.D., Millburn
El Ballesteros Castro, M.D., Newark
Vincent C. Giampapa, M.D., Belleville
C. Clayton Griffin, M.D., Newark
David J. Jacobs, M.D., Short Hills
Walter J. Molofsky, M.D., Newark
Arnold Schonmuller, M.D., Newark
Carlos R. Vargas, M.D., Newark
Daniel Zacharias, M.D., Maplewood

Gloucester County

Howard H. Buxbaum, M.D., Swedesboro
Dong Sup Cha, M.D., Woodbury
Eileen M. Moynihan, M.D., Haddon Heights
Robert J. Terranova, D.O., Sewell

Hudson County

Tomas J. Barrios, M.D., Union City
Rosa M. Gonzalez, M.D., West New York

Munir A.A.Q. Hasan, M.D., Jersey City
Sophie H. Pierog, M.D., Jersey City
Deborah H. Wozniak, M.D., Bayonne

Hunterdon County

Paul P. Madura, Jr., M.D., Hampton
Kevin K. Mooney, M.D., Ringoes
David V. Nenna, M.D., Flemington

Mercer County

Lauri D. Ervin, M.D., Princeton
Bartley A. Larsen, M.D., Lawrenceville
Bruce L. Safman, M.D., Lawrenceville
Floyd Weinstock, M.D., Lawrenceville

Middlesex County

Fazlur R. Panezai, M.D., Edison
Matthew H. Smith, M.D., Iselin

Monmouth County

Saroj Dhamija, M.D., Middletown
Barry L. Swick, M.D., Long Branch

Morris County

Natalie I. Bilenki, M.D., Whippany
Donald J. Billmaier, M.D., Morristown
Mark A. Bronstein, M.D., Morristown
Michael M. Danber, M.D., Boonton
Ilene M. Hershman, M.D., Morristown
Lawrence W. Raymond, M.D., Florham Park
Sadhana S. Sathe, M.D., Morristown
Clifford A. Taylor, M.D., Morristown

Ocean County

Tun-Sang Chu, M.D., Toms River
Peter J. DeMuro, D.O., Jackson
Samuel D. Schenker, M.D., Lakewood

Passaic County

Ashoke Agarwal, M.D., Totowa
Michael P. Basista, M.D., Clifton
Duncan B. Carpenter, M.D., Fair Lawn
Timothy J. Droney, M.D., Upper Montclair
Edwin P. Kane, M.D., Clifton
Oscar A. Reicher, M.D., Wayne
Mark Wiesen, M.D., Clifton

Somerset County

Thomas J. Nordstrom, M.D., Bridgewater
Stephen M. Ocken, M.D., Somerville

Union County

Elizabeth W. Hill, Berkeley Heights

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ALCOHOLISM—George W. Miller, Jr., M.D., 77 Grove St., Apt. 8, Montclair, NJ 07042. UMDNJ 1980. Available.

ALLERGY/IMMUNOLOGY—Leonard Bielory, M.D., 688 Concerto La., Silver Spring, MD 20901. UMDNJ 1980. Board eligible. Solo preferred, but flexible. Available March 1985.

T.M. Bokhari, M.D., 48 Anderson Pkwy., Cedar Grove, NJ 07009. FJMC. Also infectious diseases (pediatric). Board certified (PED). Group, partnership, solo. Available.

ANESTHESIOLOGY—Cau Pham, M.D., 856 Nelson, Apt. 206, Chicago, IL 60657. Saigon (South Vietnam) 1974. Group or partnership. Available.

R.S. Saraiya, M.D., 88-25A 153rd St., Apt. 4-F, Jamaica, NY 11432. Baroda (India) 1978. Group or partnership. Available.

FAMILY MEDICINE—Laurence Levenberg, M.D., 63 Harrowgate Dr., Cherry Hill, NJ 08003. SUNY-Upstate 1966. Group, partnership, solo. Available.

GASTROENTEROLOGY—Harry D. Burack, M.D., 5548 Waterman Pl., St. Louis, MO 63112. Albany 1978. Also internal medicine. Board certified. Partnership, group, solo. Available.

Prakash V. Huded, M.D., 80-15 41 Ave., Apt. 606, Elmhurst, NY 11373. Karnatak (India) 1970. Board certified. Solo, group, partnership. Available.

H.L. Kirschenbaum, M.D., 780 Woolley Ave., Staten Island, NY 10314. New York Medical College 1977. Board eligible. Also, internal medicine. Partnership, group, full-time hospital. Available.

Neil Tarkin, M.D., 6700 192nd St., Fresh Meadows, NY 11365. New York Medical 1978. Also, internal medicine. Board certified (IM). Any type practice. Available.

Mark F. Tsai, M.D., 1715 Stanford Dr., Columbia, MO 65201. National Taiwan University 1977. Also, internal medicine. Board certified. Available.

GENERAL MEDICINE—John J. Kim, M.D., 127 Garfield Ave., Jersey City, NJ 07305. Catholic Medical College (Korea) 1966. Group, partnership, solo. Available.

INTERNAL MEDICINE—Harry D. Burack, M.D., 5548 Waterman Pl., St. Louis, MO 63112. Albany 1978. Also gastroenterology. Board certified. Partnership, group, solo. Available.

Z.U.A. Farooqui, M.D., Plaza Professional Bldg., Bayshore Rd. and Greenwood Ave., Box 238, Villas, NJ 08251. Aurangabad Medical College (India) 1972. Board eligible. Group or partnership. Available.

Aditi Gupta, M.D., 27 Sturbridge Dr. West, Piscataway, NJ 08854. Lady Hardinge (India) 1980. Board eligible. Clinic/hospital or group. Available.

Lee W. Hoffer, M.D., 1017 E. 80th St., Brooklyn, NY 11236. Rome (Italy) 1980. Solo, partnership, group. Available.

H.L. Kirschenbaum, M.D., 780 Woolley Ave., Staten Island, NY 10314. New York Medical College 1977. Boa eligible. Also, gastroenterology. Pa nership, group, full-time hospit Available.

Quang T. Nguyen, M.D., 15 Englewood Ave., Bergenfield, NJ 0762 Saigon (South Vietnam) 196 Subspecialty, nephrology. Boa eligible. Any type practice. Available

Claudia Anne Pollet, M.D., 61 Parkway Dr., Baltimore, MD 2121 Mount Sinai 1981. Board eligib Salaried position in emergency roo clinic, or urgent care center. Availab

Paul V. Renda, M.D., 3206 Myra S Apt. D, Durham, NC 27707. Mou Sinai 1981. Board eligible. Solo, grou clinic (preferably southern NJ). Ava able.

Richard B. Schwarz, M.D., 8300 D Longpre Ave., Apt. 204, Los Angeles, 90069. NYU 1979. Subspecialt nephrology. Board certified. Grou HMO, hospital. Available.

Gopal Shah, M.D., 100 Caton Ave., A 2-G, Brooklyn, NY 11218. M.R. Medic College (India) 1976. Board eligib Group. Available.

Neil Tarkin, M.D., 6700 192nd S Fresh Meadows, NY 11365. New Yo Medical 1978. Also, internal medicir Board certified (IM). Any type practi Available.

Steven Wolinsky, M.D., 1404 E. 15 S Brooklyn, NY 11230. Case Western F serve 1980. Group or partnersh Available.

NEPHROLOGY—Quang T. Nguyen, M. 15 W. Englewood Ave., Bergenfield, 07621. Saigon (South Vietnam) 19 Also, internal medicine. Board eligib Any type practice. Available.

Richard B. Schwarz, M.D., 8300 D Longpre Ave., Apt. 204, Los Angeles, 90069. NYU 1979. Also, internal me cine. Board certified (IM). Group, HM hospital. Available.

OBSTETRICS/GYNECOLOGY—Balwa K. Chhatwal, M.D., 6416 Fairfield Av Berwyn, IL 60402. Delhi (India) 197 Group, partnership, solo. Available.

Sheela Choubey, M.D., 1 Zirkel Av Piscataway, NJ 08854. Poona (Indi 1977. Board eligible. Group or partn ship. Available.

Edwin R. Guzman, M.D., 1200 E. 98 St., Brooklyn, NY 11236. New Yo Medical 1980. Board eligible. Group partnership. Available Septemb 1984.

Atul S. Sheth, M.D., 2951 S. King D Chicago, IL 60616. T.N. Medical Colle (India) 1972. Specializing in infertili reproductive endocrinology. Boa eligible. Partnership, single or multi group practice, academia. Available.

Ernest A. Topran, M.D., 3523 De berry-Southern Oaks, Shreveport, 71118. Louisiana State 1980. Group partnership. Available.

OCCUPATIONAL MEDICINE—Err Emmet Vernon, M.D., 2018 Pickert Dr., Deer Park, TX 77536. University

he West Indies (Jamaica) 1978. Board ligible. Group. Available.

DIATRICS—Dorothea H. Gross, M.D., 64 Boonton Turnpike, Lincoln Park, J 07035. Geneva (Switzerland) 1950. Clinic, group, emergency room, hospial, pharmaceutical research (salaried). Available.

Kusumam Sidharthan, M.D., 222 Yorkshire Ct., Old Bridge, NJ 08857. Calicut Medical College (India) 1976. Board eligible. Available.

DIOLOGY/NUCLEAR MEDICINE—Conrad P. Erlich, M.D., 1243 Beacon St., Apt. 3B, Brookline, MA 02146. Boston 1976. Board certified. Group or partnership. Available.

Mindy M. Horrow, M.D., 131 Pond Brook Rd., Chestnut Hill, MA 02167. Medical College of Pennsylvania 1980. Board eligible. Group, HMO, academia. Available.

Subhash S. Pujara, M.D., Box 391B, Rt. 3, Andalusia, AL 36420. B.J. Medical College (India) 1969. Board certified (radiology); board eligible (nuclear medicine). Group, partnership, solo. Available.

RGERY, GENERAL—Sara A. Case, M.D., 284 Quinby Rd., Rochester, NY 4623. Virginia 1975. Board eligible. Group—general surgery in moderate-sized city. Available.

Ruben J. Delgado, M.D., 7514 Oriental Tr., San Antonio, TX 78244. Puerto Rico 1976. Also, vascular surgery. Board certified. Single or multispecialty group or solo. Available.

Leonardo A. Garduno, M.D., 2170 S. Goebbert Rd., Apt. I-109, Arlington Heights, IL 60005. University of the East (Philippines) 1968. Any type practice. Available.

Barry Jordan, M.D., 260 Garth Rd., Scarsdale, NY 10583. South Carolina 1977. Board eligible. Group, partnership, solo. Available.

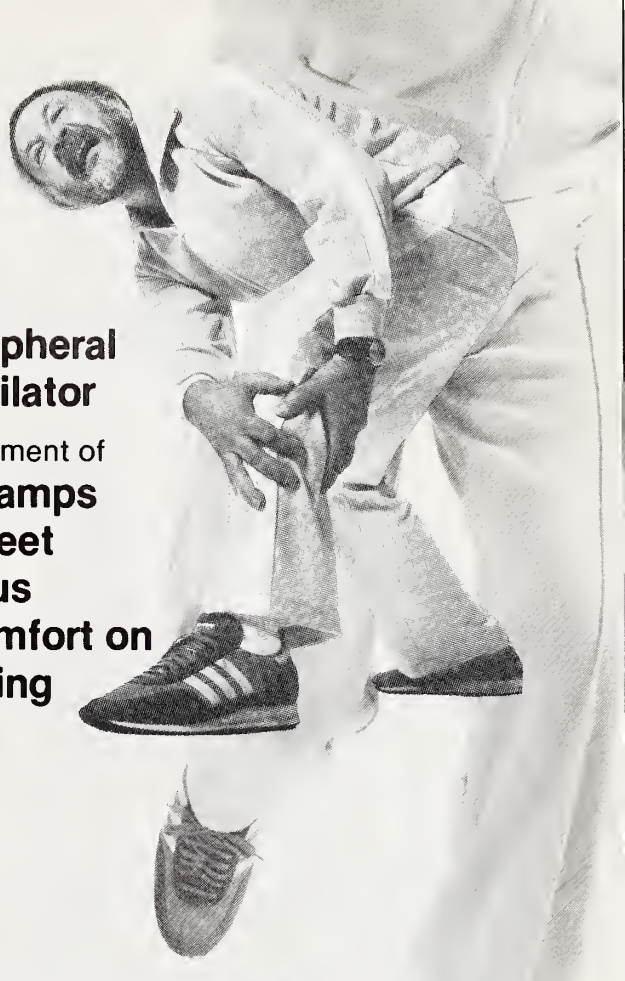
J. Bernard LeSage, M.D., P.O. Box 699, Middlesboro, KY 40965. Montreal (Canada) 1945. Board certified. Administrative medicine. Available.

James M. Stern, M.D., 600 Vista Court, Waynesboro, PA 17268. Jefferson 1958. Board certified. Solo, with freedom to practice in broad spectrum of surgery, including vascular and fractures. Available.

RGERY, ORTHOPEDIC—S.N. Saraiya, M.D., 88-125A 153rd St., Apt. 4-F, Jamaica, NY 11432. Baroda (India) 1974. Solo. Available.

RGERY, VASCULAR—Ruben J. Delgado, M.D., 7514 Oriental Tr., San Antonio, TX 78244. Puerto Rico 1976. Also, general surgery. Board certified (GS). Single or multispecialty group or solo. Available.

OLOGY—Kiritkumar M. Pandya, M.D., 950 49th St., Apt. 9-A, Brooklyn, NY 11219. Baroda (India) 1970. Board eligible. Group, partnership, solo. Available.



A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release
LIPO-NICIN®/300 mg.

Each time-release capsule contains:
Nicotinic Acid .....300 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release
LIPO-NICIN®/250 mg.

Each yellow tablet contains:
Nicotinic Acid .....250 mg.
Niacinamide .....75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide .....75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

ARE YOU A SAINT MICHAEL'S ALUMNUS?

Saint Michael's Medical Center, Newark, NJ, a 117 year old teaching hospital, is forming a medical alumni association. We are seeking some 5,000 physicians who served as residents and interns. Over the years many of our former house staff members have relocated making consistant communication difficult.

Our alumni association will be oriented towards four goals: professional, medical, social and educational. Plans are already being made for a medical reunion dinner and symposium in the fall.

If you are a former member of Saint Michael's house staff or know another staffer's whereabouts, please call (201) 877-5494 or write to:

SAINT MICHAEL'S MEDICAL CENTER
268 Dr. Martin Luther King, Jr. Blvd.
Newark, NJ 07102
attn: Office of Public Affairs

ACUPUNCTURE IN CLINICAL PRACTICE

N.Y. State Boards of Medicine & Dentistry 25-hour accredited seminar and workshop on the latest theories & techniques of manual and electro-acupuncture, applicable toward the 200-hour requirement for certification, will be given for licensed clinicians (with or without prior training) during the weekend of Sept. 9-11, 1984 and again the weekend of Oct. 26-28, 1984 at the Barbizon Plaza Hotel, New York City. Co-sponsored by the International College of Acupuncture & Electro-Therapeutics, its office journal, Acupuncture & Electro-Therap. Res., Int.J. (published by Pergamon Press and indexed in 15 major indexing periodicals; INDEX MEDICUS, etc.), the Heart Disease Research Foundation and the Neuroscience Dept. of Long Island College Hospital, Pharmacology Dept. of The Chicago Medical School. Also eligible for AMA/CME credit. For information, contact Y. Omura, M.D., ScD., 800 Riverside Drive (8-1), NYC 10032. Tel: (212) 781-6262 or (212) WA8-0658, or Saul Heller, M.D., Tel: (212) 838-7514.

7th ANNUAL CURRENT CONCERNS IN ADOLESCE MEDICINE—"A PRACTITIONERS GUIDE TEENAGE HEALTH CARE"—October 25 & 26, 198 The Warwick Hotel, New York, NY. Sponsored b Division of Adolescent Medicine, Department of Pe atrics, Schneider Children's Hospital, Long Island Je ish-Hillside Medical Center, New Hyde Park, NY. Topi include: Communicating with the Teenage Patient a Family; Hematological Problems; Anorexia Nervos Diabetes in Adolescents; Common Infections in Adole cents; Gynecology for the Practitioner; Sexually Trar mitted Diseases; Recognizing Depression; Abdomir Pain; Sports Evaluation and more. Credits 12 Categc 1 from the ACCME and AMA. Information: Ann Boehme, Continuing Education Coordinator, Lo Island Jewish-Hillside Medical Center, New Hyde Pa NY 11042, (212) 470-2114.

The *Journal* of the Medical Society of New Jersey
announces the reprinting of the

WILLIAM CARLOS WILLIAMS COMMEMORATIVE ISSUE

September, 1983

Honoring the 100th anniversary of the birth of New Jersey's prize-winning poet and physician. Included in this handsomely illustrated, full-color issue will be original articles by persons close to William Carlos Williams, artwork from his social and intellectual circle, and samples of his finest writings.

Copies of this special issue are available by sending $5.00 for each (check or money order) to MSNJ, Two Princess Road, Lawrenceville, NJ 08648.

Please send a copy of the **William Carlos Williams Commemorative Issue** to:

_____

_____

_____

Enclose a $5.00 check or money order for each copy.

ME CALENDAR

The following is a list of continuing medical education courses for the next two months. Contact the sponsoring organization for further information.

is list is compiled through the coop-ation of the Committee on Medical ucation of the Medical Society of New rsey, The Academy of Medicine of w Jersey, the New Jersey Chapter of e American Academy of Family Phy-ians, and the Office of Continuing dical Education of the UMDNJ. For ormation on accreditation, please ntact the sponsoring organization(s), dicated by italics—last line of each m.

RDIOLOGY

pt.

Advanced Cardiac Life Support-Provider
7:00 P.M.—Helene Fuld School of Nursing, Camden
(West Jersey Health System and AMNJ)

t.

Calcium and Cardiovascular Function
1:30-5:30 P.M.—Drew University, Madison
(Drew University, CIBA-Geigy Pharmaceutical Division, and AMNJ)

Pharmacological Treatment of Cardiovascular Diseases
8:30 A.M.-5:15 P.M.—Resorts International, Atlantic City
(UMDNJ and AMNJ)

MEDICINE

Sept.

6 **Evaluation and Assessment of the Allergic Child**
9 A.M.—Freehold Area Hospital
(AMNJ)

13 **Mammography and Minimal Breast Cancer**
7:45-9 P.M.—Burlington County Memorial Hospital, Mount Holly
(Burlington County Medical Society and AMNJ)

19 **Dermatological Conference**
6-9 P.M.—Rutgers Community Health Plan, U.S. Hwy #1 and Rt. 18, New Brunswick
(UMDNJ-Rutgers Medical School)

20 **Ontogeny of the Immune System**

27 **Immune Responses and Regulation**
4-6 P.M.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

20 **Advances in Pain Management**
8 A.M.-5 P.M.—Resorts International, Atlantic City
(UMDNJ and AMNJ)

21 **Bronchial Asthma-Current Concepts of Management**
9 A.M.—St. Francis Medical Center, Trenton
(St. Francis Medical Center)

Oct.

3 **Venom Therapy**
8-9:30 P.M.—The Manor, West Orange
(NJ Allergy Society and AMNJ)

4 **Immunoregulation: Basic**

11 **Concepts and Applications**

18 4-6 P.M.—Institute for Medical

25 Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

5 **Treatment of Acute Hypertension**

19 **Headache**
9 A.M.—St. Francis Medical Center, Trenton
(St. Francis Medical Center)

10 **Nephrotic Syndrome**

17 **Leukemias in the Adult**

31 **Pulmonary Rehabilitation**
1-2:30 P.M.—VA Medical Center, Bldg. 93, Lyons
(VA Medical Center and AMNJ)

11 **Medical Update: Use of Thyroid Function Tests**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

13 **Hyperthermia for Cancer**
8:30 A.M.-5 P.M.—Medical Society of New Jersey, Lawrenceville
(AMNJ)

17 **Dermatological Conference**
6-9 P.M.—Rutgers Community Health Plan, U.S. Hwy #1 and Rt. 18, New Brunswick
(UMDNJ-Rutgers Medical School)

24 **Regional CME Meeting, ACP and NJSIM**
9 A.M.-4 P.M.—Landmark Inn, Woodbridge
(American College of Physicians (New Jersey) and New Jersey Society of Internal Medicine)

27 **Basic and Practical EKG Course**
8:30 A.M.-6 P.M.—Sheraton Heights Hotel, Hasbrouck Heights
(Palisades General Hospital and AMNJ)

30 **AIDS in Children**
7-9 P.M.—Englewood Hospital Learning Center, Englewood
(Englewood Hospital and AMNJ)

NEUROLOGY/PSYCHIATRY

Sept.

5 **Computer and Clinical Psychiatry**
9:15 A.M.-4:45 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

6 **Late Onset Schizophrenia**

13 **Depression: Current Management and Future Directions**

20 **Social Management of Breast Cancer and Surgery**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

12 **The New Antidepressants**
1-2:30 P.M.—Bldg. 93, VA Medical Center, Lyons
(VA Medical Center and AMNJ)

19 **Cognitive Rehabilitation in a Geriatric Medical Center**
8:30 A.M.-4 P.M.—Bldg. 93, VA Medical Center, Lyons
(VA Medical Center and AMNJ)

20 **Symposium—New Frontiers in**

21 **Cognitive Rehabilitation**

22 All day—Hyatt Regency, Princeton
(Robert Wood Johnson, Jr. Lifestyle Institute and Natl. Head Injury Foundation)

20 **The Yarmulka in Dreams**
8-10 P.M.—Hackensack Hospital
(NJ Psychoanalytic Society and AMNJ)

Oct.

4 **Research Update: Aging, The Elderly, and E.C.T.**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

19 **The State of Psychiatry for 1984**
8:30-10:30 P.M.—Coachman Inn, Cranford
(NJ Psychiatric Association and AMNJ)

23 **Alzheimer's Disease**

24 9:15 A.M.-4:45 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

PEDIATRICS

Sept.

11 **Pediatricians' Perspective of Language Development**
9:30-10:30 A.M.—Elizabeth General Medical Center, Elizabeth
(Newark Beth Israel Medical Center and AMNJ)

FIFTH ANNUAL MEDICOLEGAL SEMINAR

Wednesday, September 12, 1984
8:30 a.m.- 4:00 p.m.

Medical Society of New Jersey Executive Offices
Two Princess Road
Lawrenceville, NJ 08648
presented by

Medical Society of New Jersey
Department of Professional
Liability Control

Medical Inter-Insurance
Exchange of New Jersey
Department of Risk Management

Morning Session

8:30 Registration and Coffee

9:00 Greetings
Frank Y. Watson, M.D., President, MSNJ and James S. Todd, M.D., Chairman of the Board, MIIENJ

9:20 **Opening Remarks**
James E. George, M.D., J.D., Director, Department of Professional Liability Control

9:45 **"The Snitch Bills; Their Impact on Medical Malpractice"**
Vincent A. Maressa, Executive Director, MSNJ

10:15 **"Reporting of Medical Malpractice To State Board of Medical Examiners"**
Floyd J. Donahue, M.D., Member of State Board of Medical Examiners

10:45 **"The New Case Management and Procedures of Malpractice Litigation"**
Honorable Peter Ciolino, Assignment Judge Superior Court, Passaic County

11:15 **Questions and Answers**

Afternoon Session

12:00 Lunch

12:45 **"Medical Malpractice; The View from the Chair"**
James S. Todd, M.D. Chairman, Board of MIIENJ

1:00 **"The Professional Liability World Today; The State of the Industry"**
Peter Sweetland, President, MIIENJ

1:45 **"The Claim Climate in New Jersey; A History and a Look at the Future"**
Joseph DeRoma, Vice-President, Claims, MIIENJ

2:30 **"An Ounce of Prevention; Causes of Suits and Programs Developed To Avoid Them"**
Adam P. Wilczek, Director, Department of Risk Management, MIIENJ

3:15 **Questions and Answers**

APPROVED FOR 5½ CME CATEGORY I CREDITS

REGISTRATION
PLEASE RESPOND NO LATER THAN AUGUST 31, 1984
NO REFUNDS AFTER SEPTEMBER 10, 1984

MSNJ MEMBER OR MIIENJ INSURED	$10.00
NON MSNJ MEMBER OR NOT INSURED WITH MIIENJ	25.00

DETACH AND MAIL TO MSNJ, TWO PRINCESS ROAD, LAWRENCEVILLE, NJ 08648

Enclosed is my check for_____payable to MSNJ

NAME (PLEASE PRINT)_____

ADDRESS_____

PHONE #_____

A CONFIRMATION WILL BE SENT TO YOU ALONG WITH DIRECTIONS TO MSNJ.

ADIOLOGY

pt.

Mammography and Minimal Breast Cancer
7:45-9 P.M.—Burlington County Memorial Hospital, Mount Holly
(Burlington County Medical Society and AMNJ)

Nuclear Magnetic Resonance
12 noon—St. Mary's Hospital, Orange
(AMNJ)

RGERY

pt.

Infectious Complications of Trauma
8 A.M.-4 P.M.—NJ Medical School, Rm. B-552, Newark
(UMDNJ and AMNJ)

Thoraco-Abdominal Aneurysm
5:15-6:15 P.M.—Shores Memorial Hospital, Somers Point
(Shore Memorial Hospital and AMNJ)

25 Regional Isolation Perfusion
8-10 P.M.—Englewood Club, Englewood
(Englewood Surgical Society and AMNJ)

SURGICAL SPECIALTIES

Sept.

20 Thoraco-Abdominal Aneurysm
5:15-6:15 P.M.—Shore Memorial Hospital, Somers Point
(Shore Memorial Hospital and AMNJ)

Oct.

23 Ophthalmology Update 1984-1985
8-10 P.M.—Englewood Club, Englewood
(Englewood Surgical Society and AMNJ)

MISCELLANEOUS

Sept.

5 Computers in Medicine/Psychiatry
9:15 A.M.-4:45 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

12 Medicolegal Seminar
8:30 A.M.-4 P.M.—Medical Society of New Jersey, Lawrenceville
(Medical Inter-Insurance Exchange of NJ, MSNJ, and AMNJ)

17 Ethnic Patterns in Health Care
1-4 P.M.—Saint Barnabas Medical Center, Livingston
(Fair Oaks Hospital, Saint Barnabas Medical Center, and AMNJ)

19 CME Workshop
9 A.M.-4 P.M.—MSNJ Executive Offices, Lawrenceville
(MSNJ and AMNJ)

Oct.

18 Nurse as Expert Witness in Court
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)



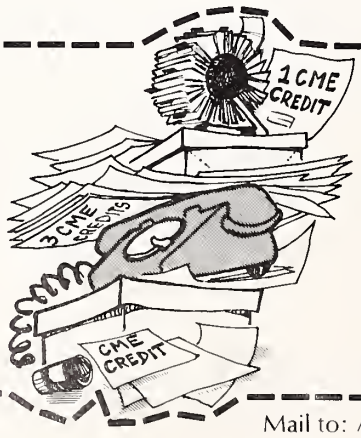
It's Not What You Know, It's How You Record It.



Most busy physicians find continuing medical education credits easier to collect than to remember.

So the Academy of Medicine of New Jersey is offering an easy system for recording and reporting CME credits for AMA recognition as well as Medical Society and professional organization membership. A computerized CME recordkeeping system is available to every New Jersey physician. All you do is send us a reporting card (which your office staff can complete). We'll keep your records and keep you informed semi-annually of your accumulation. This service is free to Academy members. Non-members (whom we encourage to join) pay $30 per year. If you're interested, complete and mail this coupon.

Note: The Medical Society of New Jersey accepts these CME Reports as documentation to meet CME membership requirements.



Please register me for AMNJ's computerized CME record-keeping service.

Name _____

Address _____

City _____ State _____ Zip _____

Telephone Number _____

Your New Jersey Medical License No. (five numerical digits only)_ _ _ _ _

Academy member: Yes ☐

No ☐ Please enclose check

Interested in Academy membership: Yes ☐ No ☐

Mail to: Academy of Medicine of New Jersey, 2 Princess Road, Lawrenceville, NJ 08648

ETTERS TO THE DITOR

Comments on the Williams Issue; DRGs—Two Viewpoints; Fulcrums and Forums and Clout; Mass for Physicians

omments on the 'illiams Issue

April 30, 1984

ear Doctor Krosnick:

Your William Carlos Williams ommemorative Issue (September 83) is an auric treasure of educa- nal and inspirational material. I und the article "William Carlos illiams and Charles Demuth" es- cially valuable.

Figure 1 of that article shows harles Demuth's 1928 painting "I aw The Figure 5 in Gold," from the fred Stieglitz Collection (1949) at e Metropolitan Museum of Art. he painting is based on Williams's oem "The Great Figure." Your read- s may be interested to know that is dynamic painting appeared as ie cover illustration for the Janu- y 2, 1981, issue of *JAMA*, accom- anied by an eloquent essay on De- uth and Williams by M. Therese outhgate, M.D.

Dr. Southgate points out (among other observations in this cover story) the painting's multiple references to William Carlos Williams's appellations and avocations, as well as the "visual Doppler effect" of the golden figure 5.

In the same issue, an autobiographical comment by Robert Coles, M.D., "William Carlos Williams: A Writing Physician," closed with these golden words: "The doctor as writer. The writer as ironic self-observer. The observer as, still, teacher to all of us—medical students and physicians and men and women everywhere, and in each generation, who crave beauty: the sight of it, the sound of it."

(signed) Steven R. Kohn, M.D.

DRGs—Two Viewpoints

May 22, 1984

Dear Doctor Krosnick:

I take exception to Vincent Maressa's article in the May 1984 issue of *The Journal* of the Medical Society of New Jersey (pages 409-410) as it represents, once again, tunnel vision on the part of the political hierarchy of the medical profession. Our leadership opposed Social Security, Blue Cross and Blue Shield, Medicare, and now DRG. If we had volunteered and gotten in on the "ground floor," less time and effort on our part would be needed now to iron out the "kinks" in the DRG system. DRG is here to stay. Dr. Bernard Rineberg is correct in calling for "true cooperation" (page 408) and this is what the public expects and demands of the medical profession. When will we ever learn?

(signed) Gerald E. Rubacky, M.D.

June 6, 1984

Dear Doctor Krosnick:

Thank you for the opportunity to respond to Dr. Rubacky's letter.

This broad and sweeping reference to historical opposition of the medical profession to Social Security, Blue Cross and Blue Shield, Medicare, and now DRG, is absolutely inaccurate.

Medical leadership did not oppose the concept of Social Security for the general population, but did oppose mandatory participation of self-employed persons.

Medicine organized, formed, and sponsored Blue Cross and Blue Shield. I can find no creditable reference regarding opposition.

Medicine did not oppose Medicare for the needy. It did oppose universal Medicare and pointed out it would be terribly expensive and create excessive demand (res ipsa loquitur).

Medicine declared DRGs to be experimental and unproved. Medicine demanded scientific investigation of the cost effectiveness and quality of care issues of DRG before they became mandated. The government did not listen. Defects should be removed before the craft is airborne. Question: Why is it valid to oppose governmental policy on Vietnam, the Middle East, Central America, the economy, and the environment, but wrong to oppose misguided governmental policy on health and health economies?

Vincent A. Maressa
Executive Director, MSNJ

Fulcrums and Forums and Clout

May 24, 1984

Dear Doctor Krosnick:

At the 1984 meeting of the Medical Society of New Jersey, a list of the 26 recognized "specialty societies" was evidenced. For a specialty society to have representation beyond recognition in MSNJ, 80 percent of its members must be members of the Medical Society of New Jersey. It is disturbing to see that of the 26 groups, exactly half have qualified for representation. I am sorry to see that my own group, the New Jersey State Society of Anesthesiologists is among the missing.

Having been observing our problems for some 50 years, I still am distressed at some of our members who are 1) indifferent, 2) take no action at all, or 3) picket outside the pale of influence. No matter how much you are for or against something, your leverage is not effective unless you can apply it at a fulcrum. That fulcrum is where push and shove meet, and is found in the forum provided by the Medical Society of New Jersey in our House of Delegates. If you want to be heard, you must have "voice," and voice is translated as "presence." That presence means that when you give voice you are seen and heard as one ac-

tively participating, and not as someone rudely aroused from medical slumbers by a prospective financial pinch or an aborted privilege. The world is still full of two kinds of people, the ones who work, and the ones content to let them. We solicit your active participation.

(signed) Edward G. Bourns, M.D.

Mass for Physicians

May 30, 1984

Dear Doctor Krosnick:

Bishop McCarrick will celebrate the second annual Mass for physicians and medical personnel at St. Francis Cathedral, Main Street, Metuchen on Sunday, October 14, 1984, at 12 noon.

This is an opportunity for the Bishop to express his gratitude to all members of the medical profession and to offer them his support and prayers.

I would ask you, as Editor of *The Journal* of the Medical Society of New Jersey, to publish an announcement and invitation to your constituents. We also would a preciate your good judgment using other means of communic ing this information. Hoping to s many medical personnel on Octol 14, I am

Faithfully yours in Chr
(signed) (Rev.) Joseph L. Desmo

Secretary to the Bish
Diocese of Metuch
Coordinator of Hea
Care Apostol

tlas of Cross-Sectional Anatomy; Clinician's Approach to Endocrine Problems; Controversies in Dermatology; Guide to Cardiology; Nelson's Textbook of Pediatrics; Technological Basis of Radiation Therapy

tlas of Human Cross-ectional Anatomy

onald R. Cahill, Ph.D., and Mat-ew J. Orland, M.D. Philadelphia, , Lea & Febiger, 1984. Illustrated. . 139. ($29.50)

This book is an atlas of the human dy in cross-sectional study. The ctions were prepared by freezing d sectioning, immediately photo-aphed to preserve anatomic rela-onships, and then fixed and dis-cted. Orientation drawings con-niently show the level of each cut. The atlas is divided into body re-ons, with separate sections of the male pelvis. Each photograph has ndamental features labeled, and e accompanying drawing of the ssected section is labeled ex-nsively.

The authors note that this work so includes many soft tissue de-ils which may not be evident on e various clinical imaging studies rrently available, but may be of natomic or pathologic interest.

This atlas should be in the library every radiographic department or fice that does C-T scanning or milar cross-sectional studies.

Joseph Peyser, M.D.

Clinician's Approach to Endocrine Problems: 45 Case Studies

C.R. Kannan, M.D. Chicago, IL, Year Book Medical Publishers, Inc., 1983. Pp. 514. ($29.95)

This book presents 45 endocrine case studies, each dealing with an individual patient with a chief complaint, history, and physical examination, followed by clinical questions, laboratory and procedure, results, and therapy. After each case the author discusses answers to questions with the end result being a very satisfactory learning experience for each topic discussed.

The case topics are varied and include types of Cushing's syndrome, hyperaldosteronism, pheo, AGS, prolactinoma, various associated endocrinopathies, DI, inappropriate ADH, various thyroid syndromes, diabetic syndromes, amenorrhea, male endocrine syndrome, precocious puberty, Z-E syndrome, and hyperlipidemia.

The text is very informative and draws from reference material quoted at the conclusion of each case presentation. Some important values are that the text brings what has been established in research and laboratory endocrinology to its manner of use in clinical daily case handling and decision making, and allows the reader to compare methods of diagnosis and therapy. Finally, the discussion justifies the ordered systematic selection of procedures in arriving at the diagnosis. The differential diagnosis is presented nicely with a good discussion of what can be ruled in or out. The methods of suggested diagnostic procedure are detailed, with results followed by a quoted range of included norms.

There is a very good method of presentation of selected endocrine cases for the student of clinical endocrinology.

Mark M. Singer, M.D.

Controversies in Dermatology

Ervin Epstein, M.D. Philadelphia, PA, W.B. Saunders Company, 1984. Pp. 482. Illustrated. ($55)

This book represents a group of subjects in the field of dermatology which are considered as worthy of assembling one or more opinions by current investigators and author-practitioners. Some of the controversy does not appear in the text itself, since the editor indicates that a number of potential contributors did not feel there was need for anything further to be written, other than the accepted knowledge in the medical literature or their specific course of management of a condition.

There are a total of 14 sections in the book and each is well written by the numerous contributors. The editor generally has a comment—his own or a reflection on the opinions of the authors—at the end of the sections and completes his page with a terse, "Think it over."

Controversies in Dermatology is a hardcover book, but I would not consider it to be a textbook; it is more of a philosophical discussion on most of the subjects considered or adjudged to be controversial, insofar as the editor is concerned. It is quite up to date and it would be apropos in an academic medical library, rather than as an addition to one's personal collection.

Murray Kahn, M.D.

The Guide to Cardiology

Robert A. Kloner, M.D., (ed). New York, NY, John Wiley & Sons, 1984. Pp. 624. Illustrated. ($29.95)

This book on cardiology contains most of the important ingredients of the specialty presented in a clear and practical manner by a group of 28 authors and the editor, R.A. Kloner. It begins in the usual fashion with descriptions of electrocardiography, cardiac physiology, and cardiac radiology. This type of introductory material is found in almost all of the numerous cardiac texts, so the better creative representation of the subject comes in later chapters.

Arteriosclerotic heart disease with its manifestations of angina, coronary spasm, stenosis, myocardial infarction and heart failure, diagnosis, and treatment are well handled. There are chapters on pericardial disease, infective endocarditis, cardiac tumor, hypertension, and hyperlipidemia.

Pulmonary embolus and pulmonary hypertension have a chapter but I would have liked more on cor pulmonale, a disease most often

seen in the aging population with chronic obstructive pulmonary disease.

There is even a good discussion of noncardiac surgery in the cardiac as well as cardiopulmonary resuscitation.

The large number of contributors does not make the text redundant or overlapping, apparently due to the careful work of the editor.

This book is meaty, precise, and practical—ideally suited for the cardiac clerk, intern, resident, and medical practitioner. Surgeons might find it a handy guide when faced with a cardiac problem.

If you do not have a good complete up-to-date cardiac text, go out and buy this one.

Manuel J. Rowen, M.D.

Nelson's Textbook of Pediatrics, 12th Edition

Richard E. Behrman, M.D., and Victor C. Vaughan, III, M.D., (eds). Philadelphia, PA, W.B. Saunders Company, 1983. Pp. 1,899. Illustrated. ($75)

This text, one of the two classical single-volume American texts of general pediatrics, has come out in a new edition which, in my opinion, is satisfactory justification for the expense involved. While no one agrees with everything, a random sample of articles on topics about which I felt comfortable yielded a high percentage of concurrence with my own experience and knowledge of the literature. The index, which in past editions has not always been as comprehensive as I would like, seems to have improved. There are many very useful tables and flow charts.

Avrum L. Katcher, M.D.

Technological Basis of Radiation Therapy: Practical Clinical Applications

Seymour H. Levitt, M.D., and Norah duV. Tapley, M.D. Philadelphia, PA, Lea & Febiger, 1984. Pp. 336. Illustrated. ($45)

This excellent text on the "how to" of radiation therapy is the companion book to Dr. Gilbert H. Fletcher's classic *Textbook of Radiation Therapy*, which for many years has been the bible to most radiation oncologists. Each chapter is written by different well-known experts in their fields and the overall quality of their presentations is superb. Althou we may differ with some of the d tails of the methods of therapy, sin one's experience may favor a d ferent approach, in general the d scriptions of the methodology a detailed, well-illustrated, and full useful and practical information which many therapists will be refe ring on a daily basis in their trea ment planning.

A listing of some of the subjects the chapters will indicate the flav of this book: rationale for treatme planning, treatment aids for e ternal beam radiotherapy, compl field arrangements, dosimetry, inte stitial techniques, iridium ten plates, and the use of compute tomography in treatment plannin

Irradiation techniques for trea ment of neoplasms of the head ar neck, lung and esophagus, brai gynecologic system, breast, prostat testes, urinary bladder, an lymphatic system are well describe I predict that this book will be o every radiation oncologist's bool shelf next to Dr. Fletcher's tome an will be well worn and thumbe through in short order as becom any useful classic. This book is re ommended to all radiologists an residents who practice radiatio therapy.

Sidney Ketyer, M.I

Drs. Abel; Bump; Byck; DeVivo; Dickinson; Fischer; Gardam; Good; Hitzemann; Juhasz; LaPorta; Myers; Voss; White; and Willoughby

Dr. Henri E. Abel

A senior member of the Union unty Medical Society, Henri nest Abel, M.D., died on May 11, 84. Born in Elizabeth in 1899, Dr. el received his medical degree at rnell University's Medical School 1924. He began his career as a neral practitioner, but in 1945, Dr. el began specializing in derma- ogy, and in 1963, he and three of children, formed the Elizabeth rmatology Group. He retired from ive practice in 1981, having been liated with Elizabeth General spital over 30 years. Dr. Abel had n chief of staff for 3 years, had n president of the New Jersey rmatological Society, and had ved his county medical society h as president and treasurer. Dr. el was a member of the American dical Association.

Dr. S. Calthrop Bump

S. Calthrop Bump, M.D., a member of our Bergen County component, died on May 5, 1984. A native of Syracuse, New York, born in 1906, Dr. Calthrop received his medical degree at the University of Rochester's School of Medicine in 1935. He specialized in orthopedic and traumatic surgery, and had been director of that specialty at The Valley Hospital, Ridgewood. Dr. Bump also served as chairman of the medical board and chairman of the surgical control, disaster, and records committees at the hospital. In addition, he donated much of his free time to the Cerebral Palsy Center in Ridgewood. Dr. Bump was a Fellow of the American College of Surgeons as well as the International College of Surgeons, and a member of the American Medical Association.

Dr. Louis Byck

We just have learned of the death in October 1983 of Louis Byck, M.D., formerly a member of the Essex County component, and residing in Santa Rosa, California. A native of Philadelphia, born at the turn of the century, Dr. Byck was graduated from Columbia University's College of Physicians and Surgeons in 1925. Specializing in allergies, he established a practice in East Orange, and had been affiliated with Newark Beth Israel Medical Center. Dr. Byck was a member of the American Medical Association. He had been a recipient in 1975 of MSNJ's Golden Merit Award in recognition of his 50 years of medicine.

Dr. John A. DeVivo

A senior member of our Essex County component, John Americo DeVivo, M.D., died March 14 at the Veterans Administration Medical Center, East Orange. A native of Newark, Dr. DeVivo earned his medical degree at Georgetown University in 1934. Prior to his retirement in 1973, Dr. DeVivo was a surgeon in his hometown and had been affiliated with City Hospital and the Lutheran Hospital, Newark. He had served in the medical corps of the Army of the United States during World War II, attaining the rank of captain. Dr. DeVivo, a member of the American Medical Association, was 75 years old at the time of his death. Dr. DeVivo posthumously was awarded Golden Merit recognition by MSNJ at this year's Annual Meeting.

Dr. George W. Dickinson

We just have learned of the death on November 15, 1983, of George Wallace Dickinson, M.D., formerly a member of the Burlington County component. A native of Arkansas, born in 1902, Dr. Dickinson was graduated from the University of Arkansas School of Medicine in 1929. Dr. Dickinson practiced family medicine in Palymyra until 1974 when he returned to his home state where he established a clinic in DeQueen, Arkansas. In 1979, Dr. Dickinson was granted MSNJ's Golden Merit Award in honor of his 50 years of medical practice.

Dr. Alvin L. Fischer

At the untimely age of 56, Alvin L. Fischer, M.D., a member of our Union County component, died on May 20, 1984. Born in New York City, Dr. Fischer received his medical degree from the University of Lausanne's Faculty of Medicine, Switzerland, in 1958. He specialized in obstetrics and gynecology in Elizabeth, and was affiliated with both Saint Elizabeth and Elizabeth General Hospitals. Dr. Fischer was board certified in his specialty.

Dr. Joseph W. Gardam

An internist for over 50 years in Newark, Joseph William Gardam, M.D., died in Riverview Medical Center, Red Bank, on May 7, 1984. Born in Brooklyn, Dr. Gardam received his medical degree from New York Medical College in 1916. He had been affiliated with Saint Barnabas Medical Center, Livingston, and also had worked in the Newark Health Department, in charge of the communicable disease division. He was board certified in internal medicine-cardiovascular diseases, and was a Fellow of the American College of Physicians. He had been a member of the American Medical Association, and in 1966, Dr. Gardam was a recipient of MSNJ's Golden Merit Award, honoring his 50 years of practice. Dr. Gar-

dam was 88 years old at the time of his death.

Dr. Charles K. Good

Charles Kemm Good, M.D., a dermatologist in Union City, died at his home on May 1, 1984. Born in Jersey City, Dr. Good was graduated from Cornell University Medical College in 1929. He was affiliated with Christ Hospital, Jersey City, and the Skin and Cancer Clinic in New York City. Dr. Good was a Fellow of the American Academy of Dermatology and a Fellow of the New York Academy of Medicine, as well as being board certified in his specialty. He also was a member of the American Medical Association. Dr. Good received MSNJ's Golden Merit Award in 1979 marking his 50 years in medicine.

Dr. Louis A. Hitzemann

A senior member of our Bergen County component, Louis Anthony Hitzemann, M.D., died on May 20, 1984. Born in Missouri at the turn of the century, Dr. Hitzemann obtained his medical degree from St. Louis University in 1925. He established his practice in Hackensack, specializing in medical problems of the eye, ear, nose, and throat. He was affiliated with Holy Name Hospital, Teaneck and the Eye and Ear Infirmary, Newark. Dr. Hitzemann was board certified in otolaryngology, and a Fellow of the American Academy of Ophthalmology and Otolaryngology. He was honored with MSNJ's Golden Merit Award in 1975 in recognition of his 50 years in medicine.

Dr. Nicholas M. Juhasz

Nicholas Miklos Juhasz, M.D., a family practitioner in Neptune City, died May 25, 1984, at Jersey Shore Medical Center. Born in Hungary in 1919, Dr. Juhasz obtained his medical degree at the United Peter Pazmany University in Budapest, in 1945. He emigrated to the United States in 1950, and established his practice in Neptune City in 1959. Dr. Juhasz was affiliated with Jersey Shore Medical Center, Neptune, and had been a member of the American Medical Association and an Associate Fellow of the American College of Angiology.

Dr. Michael L. LaPorta

At the untimely age of 57, Michael Luigi LaPorta, M.D., died at Reggio Calabria, Italy on May 19, 1984. Dr. LaPorta was born in Calimera-Lecce, Italy and was graduated from the University of Rome's School of Medicine in 1953. Emigrating to the United States that same year, he practiced his specialty, anesthesiology, in the West Long Branch and Sea Girt areas for the next 15 years. In 1967, Dr. LaPorta did volunteer work in Colombia, South America, with Project HOPE; among his services was teaching three native doctors his specialty and lecturing to medical students in Spanish. Dr. LaPorta was board certified in anesthesiology, a Fellow of the International College of Surgeons, a Fellow of the American College of Anesthesiologists, and a member of the American Medical Association. At the time of his death, Dr. LaPorta was head of the anesthesiology department and intensive care unit at Brindisi Regional Hospital in southern Italy.

Dr. Norman V. Myers

Norman Van Sant Myers, M.D., a member of our Bergen County component, died on April 28, 1984. Born in Pleasantville in 1908, Dr. Myers was graduated from Jefferson Medical College in 1933. He established a practice in proctology in Englewood, and was affiliated with Englewood Hospital for many years. Dr. Myers was president of the New Jersey Proctologic Society in 1958, and was a member of the American Medical Association. During World War II he served in the United States Navy with a rank of lieutenant commander. In 1983, Dr. Myers received MSNJ's Golden Merit Award honoring his 50 years as a physician.

Dr. John C. Voss

Congestive heart failure claimed the life on May 17, 1984, of John Carl Voss, M.D., a retired physician of Riverton. A native of Reading, Ohio, born in 1908, Dr. Voss received his medical degree at Temple University School of Medicine in 1934. He was a practitioner of family medicine, and, prior to his retirement in 1976, had been affiliated with Zurbrugg Memorial Hospital, Riverside. Dr. Voss was a member of the American Medical Association and of our Burlington County component.

Dr. Thomas J. White

A recipient of MSNJ's Gold Merit Award in 1975, Thom Joseph White, M.D., died on May 2 1984, in St. Vincent's Hospital, N York City. Born in Jersey City, I White received his medical deg from Cornell University Medical C lege in 1925, and until his reti ment in 1981 had practiced as internist and cardiologist in h native city for 56 years. Dr. Whi was a professor of medicine at Set Hall University and UMDNJ-N Jersey Medical School, and chief medicine at St. Francis Hospit Jersey City and St. Mary's Hospit Hoboken. Dr. White was a Fellow the American College of Physicia and a Diplomate in internal me cine/cardiovascular diseases. served for 20 years as chairman the board of the Blue Shield Plan New Jersey, had been president the New Jersey Heart Associatio and was a founder of the Hudso County Heart Association. Dr. Whi was a past president of The Acaden of Medicine of New Jersey, a memb of the Board of Managers at Jers City Medical Center, and person physician to former Mayor Frar Hague. He was 87 years old.

Dr. Frances L. Willoughb

Frances Lois Willoughby, M.D., th first woman doctor to serve in th United States Navy, died on May 1 1984, at Underwood Memorial Ho pital, Woodbury. Born in 1905, i Harrisburg, Pennsylvania, D Willoughby received her medic degree from the University of Arka sas School of Medicine in 1938. Sh practiced psychiatry in Glassbor until 1944 when she was inducte into service by the United State Navy with the rank of captain. Sh served until 1964 when she r turned to practice in Glassboro. D Willoughby was a member of ou Gloucester County component, an a member of the American Medic Association. She was affiliated wit Underwood Memorial Hospital. D Willoughby was a Fellow of th American Psychiatric Associatio and of the American Association fo the Advancement of Science, as we as being a Diplomate in psychiatr and neurology. In 1981, D Willoughby received the Benjami Rush Award, the nation's most pres tigious citation in psychiatry.

AUTHOR INFORMATION

Style Sheet

The Journal is the official organ of the Medical Society of New Jersey. The goals of* The Journal *are educational and informational. All material published in* The Journal *is copyrighted by MSNJ.

ONTENT

The educational content of each ue appears as scientific articles, sed on research, original concepts ative to epidemiology of disease, d treatment methodology; case re- rts based on unusual clinical ex- riences; review articles; clinical tes, succinct items on some pect or new observation or tech- que of a case experience; and ecial articles, which include evalu- ons, policy and position papers, d reviews of nonscientific sub- cts. Other topics include commen- y (critical narration); medical his- y; therapeutic drug information; diatric briefs; nutrition update; d an opinion column. Editorials e prepared by the Editor and by est contributors on timely and rel- ant subjects; editorials are the re- onsibility of the author. The Doc- s' Notebook section contains or- nizational, informational, and ad- nistrative items from MSNJ and m the community. Letters to the litor and book reviews are wel- me and will be published as space rmits. The principal aim in the eparation of a contribution ould be relevance to diagnosis and eatment and to education of pa- nts and professionals. Preference ll be given to professional authors m New Jersey and to out-of-state turers who submit a suitable manuscript based on a presentation made in New Jersey.

ASSIGNMENT OF COPYRIGHT

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978), a transmittal letter or a separate statment accompanying material offered to *The Journal* of the Medical Society of New Jersey must contain the following language and must be signed by all authors:

"In consideration of *The Journal* of the Medical Society of New Jersey taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *The Journal*, MSNJ."

SPECIFICATIONS

Submit two **manuscripts** that must be typewritten and double-spaced on 8½" by 11" paper. Statistical methods used in articles should be identified. Acknowledgements will be made only for specific preparation of an essential part of the manuscript.

Authors are asked to seek clarity, accuracy, and originality; attention to details of grammar, spelling, and typing are important.

The **title page** should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

The author should submit a 40-word **abstract** to be used at the beginning of the article.

Tables must be typewritten and double-spaced on separate 8½" by 11" sheets, with a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source; written permission for republication from the original publisher must be submitted. The cost of color photographs must be borne by the author.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

The **summary** of the article should not exceed 250 words; it should contain only essential facts.

References should not exceed 35 citations except in review articles, and should be cited consecutively in the text by numbers in parentheses at the end of the sentence. The reference list should be typewritten and double-spaced on separate 8½" by 11" sheets in the numerical order in which they are first cited in the text. The style of reference is that of *Index Medicus:*

1. Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis.* New York, NY, McGraw-Hill, 1969, pp. 42-48.

PUBLICATION POLICY

Receipt of each manuscript will be acknowledged and a copy delivered to the Editor who refers the paper to one or more members of the Editorial Board. The final decision is reserved for the Editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. Galley proofs will be submitted to the author for correction of typographical errors.

REPRINT ORDERS

Reprints may be ordered after the author is notified that the article has been selected for a specific issue of JMSNJ. A check for the cost of reprints including remake charge if order is received after due date must accompany the order.

COMMUNICATIONS

All communications should be sent to the Editor, *The Journal*, MSNJ, 2 Princess Road, Lawrenceville, NJ 08648.

INTERNIST, FAMILY PRACTICE FREESTANDING E.R. PHYSICIAN

Multispecialty practice based in Philadelphia and Cherry Hill, N.J. Great opportunity with financial security. Staff affiliation with University Hospital. Not an HMO. Main office in Cherry Hill, N.J. 10 minutes away from Philadelphia.

CHERRY HILL HEALTH CARE ASSOCIATES, P.A.
7740 Maple Avenue
Pennsauken, NJ 08109 (609) 488-3505

PRACTICE FOR SALE

Pediatric Practice—Northeast New Jersey. Established, growing practice. Attractive lease, good staff, fully equipped, pleasant community.

Address inquiries to:

The Health Care Group
400 GSB Building
Bala Cynwyd, PA 19004
215-667-8630

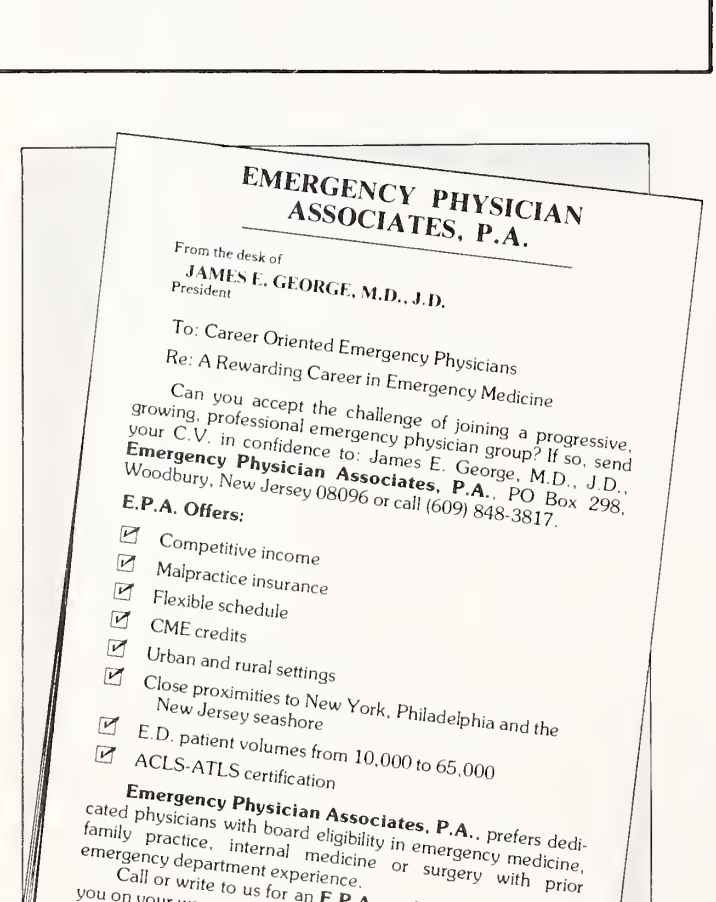
INTERNIST

Internist (part-time) needed for new clinical drug unit located in Bloomfield, New Jersey. Facility can accommodate 30-40 subjects for participation in a variety of clinical pharmacology and bioavailability studies sponsored by major pharmaceutical firms. Scientific staff consists of Pharmacologists, Biochemists, Nurses and Medical Technologists. Physician's responsibilities include:

1. Medical screening of subjects for protocol inclusion and exclusion criteria.
2. Supervision of dose administration and intensive venipuncture period.
3. Protocol review with scientific staff.
4. Representation as medical liaison to FDA and sponsor.
5. Treatment of adverse drug reactions.
6. On call hours for medical emergencies.
7. Supervision of medical support staff.
8. Liaison with local hospital emergency room.

Previous experience with clinical investigation of new drugs preferred, but not required.

Please call Dr. Chaikin, Pragma Bio-Tech, Inc., 225 Belleville Avenue, Bloomfield, New Jersey 07003, (201) 748-8624.



Need A Temporary Physician?

CompHealth treats your practice as if it were our own during: vacations, CMEs, recruiting, clinic start-up or other absences.

Want Free Time While You Practice Medicine?

Join CompHealth's Locum Tenens Physician Group.

★

For further information about temporary coverage or locum tenens practice opportunities, call:

CompHealth
A Physician Group

WILSON ROSS, Regional Administrator
244 East Hanover St.
Trenton, NJ 08608
Telephone: 609-392-1111

CLASSIFIED ADVERTISEMENTS

OBSTETRICIAN/GYNEOLOGIST—oard certified, experienced with estabshed practice in Philadelphia would like o relocate practice to New Jersey Camden or Burlington Counties). nterested in partnership and/or callnaring arrangement. Send inquiries to ox No. 93, JMSNJ.

EEDED PHYSICIANS—For successful ell known walk-in medical office center. entral NJ. Full and part time, skilled ersonable American-trained MDs. Send V to E.V. McGinley, MD, 1005 N. Washngton Avenue, Green Brook, NJ 08812. 01-968-8900.

EEDED PHYSICIANS—Part Time (Satrdays) for Family Practice in Central ew Jersey. Malpractice Insurance reuired. Phone 201-722-2522.

EEDED EQUIPMENT—Used EKG anted, also small copier and microscope r new office. If you have one available, ease contact 201-321-0188 or 201-79-8134.

QUIPMENT FOR SALE—Various office ems including physical therapy equipent. Please phone for full listing or inrmation. Livingston. 201-994-3200.

FFICE & PRACTICE FOR SALE—40 ear old solo General Practice; northern art of state. Brick, 7-room office comete with furnishings and equipment. eady to start work. Available immedicely. Owner retiring. Modern hospital. rite Box No. 91, JMSNJ.

PRACTICE—Solo Family Practice available in county seat, South Jersey. Office in home. Hospital across town. Write Box No. 85 JMSNJ.

FOR SALE—INDUSTRIAL PRACTICE—Long established, exceptional opportunity. Negotiable, Jersey City, 201-433-0742.

FOR SALE—HOUSE/OFFICE—Madison, NJ. Classic four bedroom Colonial; seven room office suite with separate entrance; parklike setting; centrally located near all area hospitals. Call Mrs. Burrows, 201-277-1398.

FOR SALE—Paramus, NJ. Residence plus 7-room office including x-ray lab. Home offers 424' deep yard, in-ground swimming pool, 8 rooms, 2½ baths, 4 bedrooms. Ample parking. The best location in Bergen County. $395,000. Call 201-843-2626.

FOR SALE—South Orange, 3 story home, professional zone near all transportation within 10 mintues of St. Barnabas, St. Marys Hospital and Hospital Center at Orange. Please address inquires to Box No. 92, JMSNJ.

OFFICE TO SHARE—Bergenfield. Centrally located professional building. Parking, furnished, 900 square feet. $450. Five minutes from hospitals. Summer 1984. Write or call Ronny Meier, MD, 297 S. Washington Ave., Bergenfield, NJ 07621. 201-385-8350.

OFFICE SPACE TO SHARE—Spacious, furnished. Located near Irvington central bus station. Ample parking. Rent very reasonable. All utilities. Call 201-540-5261.

OFFICE FOR SHARE or RENT—New Brunswick, Highland Park area. Furnished, 700 square feet. Ample parking. Close to the hospital. $500/month plus utilities, for rent. For share, $300/month including utilities. Call 201-572-5050 or 572-7553.

FOR RENT—Professional office space for rent. Millburn prestigious building, 775 square feet. On-site parking, on bus route. Call 201-731-1900.

FOR LEASE—Attractive, modern medical building, Morris Avenue, Union Center, Union, NJ. Office for lease. 750 square feet, large, private adjoining parking lot, 1st floor, no steps ... will build to suit. Phone 201-688-2480.

OFFICE SPACE FOR RENT—Professional office, 860 square feet, established medical building, junction of 3 towns, Essex County. On site parking, on bus route, near S-3 and Garden State Parkway. Write Box No. 94, JMSNJ.

OFFICE TO RENT—Manahawkin, 500 square feet plus common waiting area in new building. Full plumbing, ample parking, utilities included. Albert Poet, MD, 609-641-5500.

ATE INFORMATION FOR MEMBERS: $5.00 per insertion up to 25 words; 10 cents each additional word. Payable in advance. **ORD COUNT:** Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of umbers, hyphenated words. Count name and address as five words, telephone number as one word, and "Write Box No. 000, o JMSNJ" as six words. **COPY DEADLINE:** Fifth of preceding month.

REAL ESTATE FOR SALE

RANDOLPH—OFFICE CONDO—Prime Rt. 10 location. First floor office 1010 sq. ft. Good parking. City utilities, gas, heat. ML 208-4. $125,000.

WEICHERT CO., REALTORS
MT. LAKES/PARSIPPANY
(201) 334-9400



THE MOOLTEN LECTURES

in

POSTGRADUATE INTERNAL MEDICINE AND THERAPEUTICS

Twenty-ninth Series

Sponsored by: **Middlesex General-University Hospital, UMDNJ-Rutgers Medical School, Th Academy of Medicine of New Jersey, The New Jersey State and Middlesex County Chapters o The American Academy of Family Physicians.**

Meeting Place: Middlesex General-University Hospital—UMDNJ-Rugters Medical School, New Bruns wick, New Jersey

Date: Wednesdays, 9:00 to 11:00 A.M. starting October 10, 1984 and ending May 22, 1985.

Program Chairman: Dr. Hadley Conn, Jr., Professor, UMDNJ-Rutgers Medical School

"The Moolten Lectures in Postgraduate Internal Medicine and Therapeutics," given annually will begi their 29th year this coming October. The 1984-1985 series can fulfill 60 prescribed AAFP credits as we as 60 category I credits for the continuing education requirements of the Medical Society of New Jerse and the Physicians Recognition Award of the American Medical Association. It also can fulfill 60 credit to category 2D of the American Osteopathic Association.

As in previous years the program is designed to provide concise reviews of important advances in interna medicine that are of practical interest to internists and family practitioners. All 30 sessions are presente by outstanding physicians from the faculties of large medical centers. Participants are given the op portunity to discuss with the speakers those aspects of clinical problems that arise in the care of individua patients. The lecture topics will include Hiatus hernia, Gastritis, Peptic Ulcer, Anemia, Sexual Dysfunctio in the Male, Proteinuria, Thyroid Diseases, Hypercapneic Respiratory Failure, Diabetes, Alcoholism and many other subjects.

IF YOU ARE INTERESTED IN ENROLLING AND HAVE NOT RECEIVED AN APPLICATION FORM WRITE OR TELEPHONE THE OFFICE OF MEDICAL EDUCATION, MIDDLESEX GENERAL-UNIVERSITY HOSPI TAL, 180 SOMERSET STREET, NEW BRUNSWICK, NEW JERSEY 08901, (201) 937-8505.

The fee for the entire Course is $400. For residents $100. Discounts for early registration. Parking is available.

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY
SEPTEMBER 1984



300 YEARS OF MEDICINE IN NEW JERSEY

The Library
Acquisitions Division

LIBRARY
U.C. SAN FRANCISCO
SEP 20 1984

Send this coupon for no-obligation information of the savings under the Medical Society of New Jersey Endorsed Insurance Plans

Check this list against your coverages . . . .

- ☐ $5000 Monthly Guaranteed Convertible Accident and Health
- ☐ $10,000 Monthly Practice Overhead Expense
- ☐ $1,250,000 Term Life Insurance
- ☐ $500 Deductible COMPREHENSIVE MILLION-DOLLAR MAJOR MEDICAL PLAN—No other coverage needed—Issuable to Age 69
- ☐ $15,000 Deductible MILLION-DOLLAR UMBRELLA MAJOR MEDICAL PLAN for holders of Blue Cross and other Major Medical Plans—Issuable to Age 69
- ☐ $100-a-day Hospital Income Policy
- ☐ $200,000 High Limit Accident Plan
- ☐ Keogh and Corporate Plan NOW! $15,000 KEOGH

E. & W. Blanksteen Agency, Inc.

E. & W. Blanksteen
75 Montgomery St.,
Jersey City, N.J. 07302
(201) 333-4340
or 1-800-BLANKAG

Name: _____

Address: _____

_____

Tel. No. _____

Best Time To Call _____

The IBM Personal Computer
A tool for modern times
in the Medical Office.

MEDI-SCAN®, Authorized IBM® Value-Added Dealer for the Personal Computer

Our Comprehensive $8,995.00 MEDI-SCAN In-office Billing And Accounting System Includes:

The IBM Personal Computer XT with 128K, 10 Megabyte hard disk.

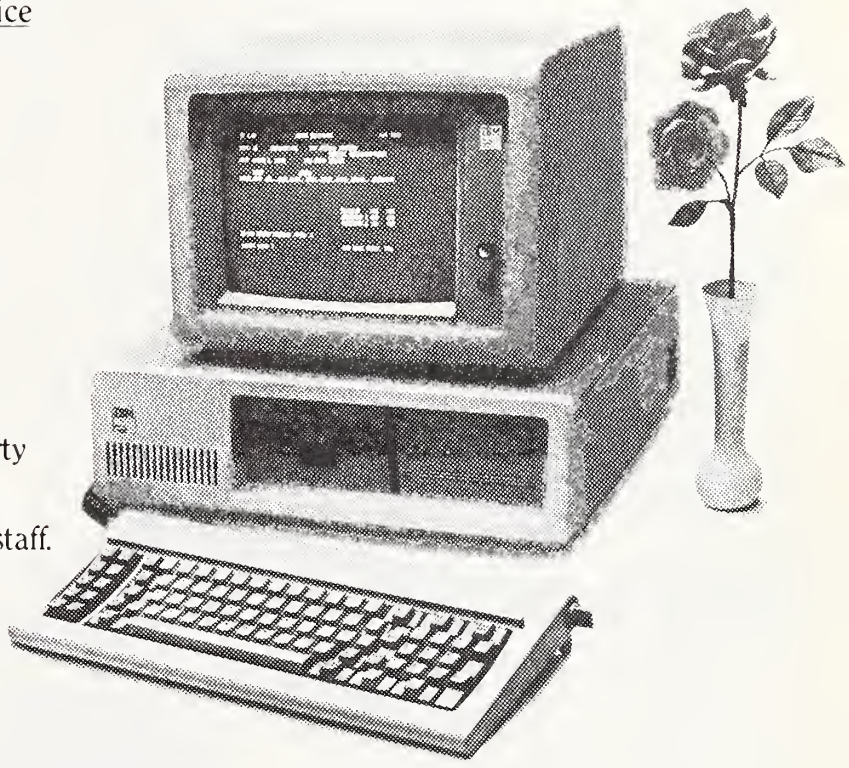
The IBM Graphics Printer.

MEDI-SCAN software—customized for your practice, including procedure numbers for state agencies. Generates accounting reports, comprehensive patient statements, insurance and third party forms.

Optional electronic paperless billing to third party agencies, where applicable.

Training—Complete in-office training for your staff.

Support—"HOT-LINE" 800 number for continuous support.



MEDI-SCAN Single Source Support System

MEDI-SCAN'S unique, comprehensive hardware and software maintenance agreement guarantees continuing service and repair, system updates and additional customization, plus in-office training—all from one source. Our local training consultants and technicians are dedicated to giving you the best possible service.

IBM Personal Computer XTs are in stock in our local warehouses ready to be immediately installed. Over five hundred physicians are using the MEDI-SCAN System—join them in making the IBM PC-XT "A tool for modern times in the medical office."

Approved nationwide by over 25 third party carriers for electronic claims submission

I would like to know more about the MEDI-SCAN System on the IBM Personal Computer XT.

Dr. _____

Address _____

City _____ State _____ Zip _____

Phone (___) _____

Or call: 800-922-1021
In MA: 800-462-1009

IBM Authorized Value Added Dealer Personal Computers

Send to: **MEDI-SCAN**
90 Madison Street, Worcester, MA 01608

MEDI-SCAN

Service centers currently in: *New England* · *Mid Atlantic States* · *Mid Western States* · *California* · *Texas*

®MEDI-SCAN is a registered trademark of PAL Assoc. Inc.
PAL Associates is an Authorized IBM Value-Added Dealer for the Personal Computer.
®IBM is a registered trademark of International Business Machines Corporation.

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

Officers and Trustees

PRESIDENT AND CHAIRMAN OF THE BOARD
Frank Y. Watson, M.D. (Essex) ..... Glen Ridge
PRESIDENT-ELECT
Ralph J. Fioretti, M.D. (Bergen) ..... Rochelle Park
FIRST VICE-PRESIDENT
Edward A. Schauer, M.D. (Monmouth) ..... Farmingdale
SECOND VICE-PRESIDENT
Harry M. Carnes, M.D. (Camden) ..... Audubon
IMMEDIATE PAST-PRESIDENT
Alexander D. Kovacs, M.D. (Union) ..... Scotch Plains
SECRETARY
Arthur Bernstein, M.D. (Essex) ..... South Orange
TREASURER
Paul J. Hirsch, M.D. (Somerset) ..... Bridgewater

Trustees

Joel S. Cherashore, M.D. (1986) (Essex) ..... Nutley
Douglas M. Costabile, M.D. (1987) (Union) ..... Murray Hill
Palma E. Formica, M.D. (1987)
(Middlesex) ..... New Brunswick
Harry W. Fullerton, Jr., M.D. (1985)
(Salem) ..... Carney's Point
Frank Gingerelli, M.D. (1986) (Bergen) ..... Hackensack
Michael M. Heeg, M.D. (1987) (Mercer) ..... Trenton
Louis L. Keeler, M.D. (1985) (Camden) ..... Collingswood
John P. Kengeter, M.D. (1987) (Ocean) ..... Toms River
Edwin W. Messey, M.D. (1985) (Burlington) ..... Willingboro
Myles C. Morrison, Jr., M.D. (1985) (Morris) .... Morristown
John J. Pastore, M.D. (1986) (Cumberland) ..... Vineland
Carl Restivo, Jr., M.D. (1987) (Hudson) ..... Jersey City
Bernard Robins, M.D. (1987) (Essex) ..... Springfield
Gerald H. Rozan, M.D. (1987) (Passaic) ..... Wayne

Councilors

FIRST DISTRICT
(Essex, Morris, Union, and Warren Counties)
Edward M. Coe, M.D. (1987) ..... Cranford
SECOND DISTRICT
(Bergen, Hudson, Passaic, and Sussex Counties)
Robert A. Weinstein, M.D. (1986) ..... Newton
THIRD DISTRICT
(Hunterdon, Mercer, Middlesex, and Somerset Counties)
Louis G. Fares, M.D. (1985) ..... Trenton
FOURTH DISTRICT
(Burlington, Camden, Monmouth, and Ocean Counties)
Frederick W. Durham, M.D. (1987) ..... Haddonfield
FIFTH DISTRICT
(Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties)
Paul H. Steel, M.D. (1986) ..... Atlantic City

AMA Delegates

William J. D'Elia, M.D., *Chairman* (1985) ..... Spring Lake
Alfred A. Alessi, M.D. (1986) ..... Hackensack
Frederick W. Durham, M.D. (1986) ..... Haddonfield
Palma E. Formica, M.D. (1986) ..... New Brunswick
Karl T. Franzoni, M.D. (1986) ..... Trenton
John S. Madara, M.D. (1986) ..... Salem
Henry J. Mineur, M.D. (1986) ..... Cranford
Myles C. Morrison, Jr., M.D. (1985) ..... Morristown
Howard D. Slobodien, M.D. (1985) ..... Metuchen

AMA Trustee

James S. Todd, M.D. (Ridgewood) ..... Bergen

September 1984

Publication Committee

Paul J. Hirsch, M.D., *Chairman*
Dirck L. Brendlinger, M.D.
Frederick B. Cohen, M.D.
A. Olusegun Fayemi, M.D.
Robert M. MacMillan, M.D.
Leon G. Smith, M.D.
La Verne Fioretti

Editor

Arthur Krosnick, M.D.

Managing Editor

Geraldine R. Hutner

Assistant Managing Editor

Dorothy J. Griffith

Advertising Manager

E. Elizabeth Cookson

Executive Director

Vincent A. Maressa

Executive Director Emeritus

Richard I. Nevin

Editorial Board

Jerome Abrams, M.D. (Obstet/Gynecol)
Joseph Alpert, M.D. (Vasc Surg)
Harold Arlen, M.D. (Otolaryngol)
Alfonse Cinotti, M.D. (Ophthalmol)
Robert Dodelson, M.D. (Nephrol)
Norman H. Ertel, M.D. (Int Med/Endocrinol)
Daniel P. Greenfield, M.D. (Psychiat)
Christine E. Haycock, M.D. (Sports Med)
Monroe S. Karetzky, M.D. (Pulmon Med)
Avrum L. Katcher, M.D. (Pediatr)
Stanley C. Leonberg, Jr., M.D. (Neurol)
Joel D. Levinson, M.D. (Gastroenterol)
Joseph A. Lieberman, III, M.D. (Fam Med)
Alan J. Lippman, M.D. (Oncol)
Henry R. Liss, M.D. (Neurosurg)
Geobel A. Marin, M.D. (Int Med/Gastroenterol)
Donald G. McKaba, M.D. (Allergy)
Robby Meijer, M.D. (Plas Surg)
Frank T. Padberg, Jr., M.D. (Surg)
Christopher A. Papa, M.D. (Dermatol)
Norman Riegel, M.D. (Book Review)
Edwin L. Rothfield, M.D. (Cardiol)
Benjamin F. Rush, Jr., M.D. (Surg)
Morris H. Saffron, M.D. (Med His)
Mark M. Singer, M.D. (Int Med/Endocrinol)
Sheldon D. Solomon, M.D. (Rheum)
Lloyd N. Spindell, M.D. (Radiol)
A. Arthur Sugerman, M.D. (Psychiat)
Stephen F. Wang, M.D. (Pediatr)
Edwin S. Wilson, M.D. (Radiol)
Louis S. Zeiger, M.D. (Nucl Med)
Robert B. Zufall, M.D. (Urol)

The Journal of the Medical Society of New Jersey (ISSN-0025-7524) is published monthly (since 1904) except semimonthly in July (13 issues), under direction of the Committee on Publication, by the Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648. Printed in East Stroudsburg, PA, by the Hughes Printing Co. Whole number of issues 966. Member's subscription ($10) is included in Society dues. Rates for nonmembers, $20; outside USA add $7.50 for postage. Single copies, $2. Address communications to *The Journal* MSNJ, Two Princess Road, Lawrenceville, NJ 08648, (609) 896-1766. Second-class postage paid at Trenton, NJ, and additional entry office.

Copyright 1984 by the Medical Society of New Jersey.

"A MIDLANTIC CREDIT LINE CAN PUT $100,000 RIGHT AT YOUR FINGERTIPS."

"Investments. Auctions. College. siness expansion.

"Will you have ready capital when lden opportunities knock? The Hungry nkers say 'Yes.'

"We give you a choice of credit lines t put you in touch with a whole world of ancial freedom.

"Chec-King, for instance, adds the nvenience of a line of credit to your idlantic checking or OW account. henever you ed money, ite a check p to the nit of your edit line.

"Need a larger line of credit? Try our Capital Line[sm] account on for size. It gives you a standing line of credit. Anywhere from $10,000 to $100,000.

"Any time a great opportunity comes your way, simply write one of your Capital Line checks. As often as you like. For as little as $500. Or as much as $100,000.

"Applying is easy, too. Just stop by any Midlantic office. Our brief application could be the last of its kind you'll ever have to fill out.

"Let the Hungry Bankers put up to $100,000 of financial leverage right at your fingertips.

"Then, when you need it, you've got it."

FOOD FOR THOUGHT FROM THE HUNGRY BANKERS

MIDLANTIC



Bob Van Buren, Chairman, Midlantic Banks Inc.

Member FDIC
Equal Opportunity Lender

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY
SEPTEMBER 198

MEDICAL HISTORY

701 The Lenape Contribution to New Jersey Medicine
Thomas P. Fitzpatrick, Teaneck

709 A Sketch of Medicine in New Jersey to 1825
Morris H. Saffron, M.D., Lawrenceville

718 MSNJ: America's First and Oldest Medical Society
Geraldine Hutner, Lawrenceville

723 The History of Medical Journalism in New Jersey
Arthur Krosnick, M.D., Lawrenceville

731 Preliminary Report of Yellow Fever During the 18th Century
William J. Snape, M.D., and Edward L. Wolfe, Ph.D., Haddonfield

737 The History of Medicine and Medical Care in New Brunswick
Norman Reitman, M.D., Highland Park

740 The Life and Times of Camden
Sam Alewitz, Ph.D., Gloucester Township

ON DISPLAY

747 The Science and Art of Healing
Stuart Sammis and Eric Dummett, Newark

MEDICAL PERSONALITIES

759 Samuel Alexander, M.D., and the Uniform Medical Practice Act
Stewart F. Alexander, M.D., Park Ridge

765 Frederick B. Kilmer: A Notable New Jersey Pharmacist
Roy A. Bowers, Ph.D., New Brunswick

769 William Augustus Newell, M.D., and the Life Saving Service
Peter J. Guthorn, M.D., Brielle

773 Women Physicians in New Jersey: The Early Era
Christine E. Haycock, M.D., Newark

779 A Medical Dynasty in New Jersey
Estelle Brodman, Ph.D., Hightstown

MEDICAL SPECIALTIES

785 The Academy of Medicine of New Jersey: A Brief History
Morris H. Saffron, M.D., Lawrenceville

791 Medical Education of New Jersey: The Development of UMDNJ
Stanley S. Bergen, Jr., M.D., Newark

798 The First 40 Years of Osteopathic Medicine in New Jersey
Robert L. Thompson, Ed.D., and Christine Chico, D.O., Piscataway

802 The History of the New Jersey Hospital Association
Linda Staab, Princeton

805 New Jersey State Nurses' Association
Janet L. Fickeissen, R.N., Lanoka Harbor

BIBLIOGRAPHY

807 New Jersey Medical Historiography: 1964-1984
David L. Cowen, M.A., Litt.D., Rossmoor

MSNJ DEPARTMENT

811 CME Calendar

On The Cover: *The Journal* is celebrating 300 years of medicine in New Jersey. This issue highlights the history of medical care in the Garden State. Our cover is by Frank Cecala.

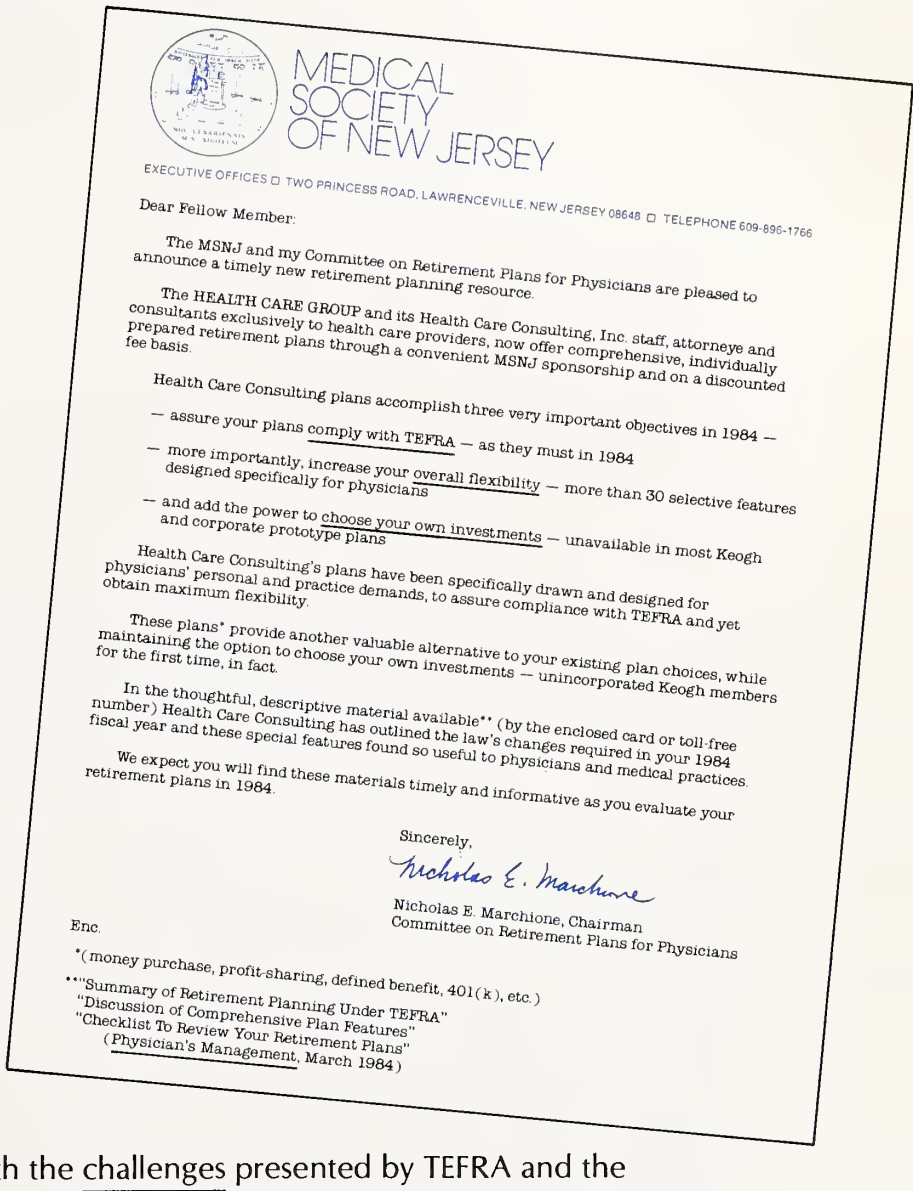


SNJ Members . . .

e has never been a better time to improve your Keogh and Corporate Retirement Plans

th Care Consulting, Inc. (HCC), primary
ite of THE HEALTH CARE GROUP, and
Medical Society of New Jersey introduce
ely program for individually designed
ement plans—

- drafted **exclusively** for physicians' practice needs
- containing more than 30 **comprehensive,** frequently overlooked features invaluable to medical practices
- complying with **TEFRA** as you must in 1984
- allowing the same **physicians directed investment** choices for incorporated and unincorporated practices
- and providing **innovative Ongoing Plan Service**—accessibility to consultation and advice, routine amendments and our exclusive Retirement Planning Newsletter



MEDICAL SOCIETY OF NEW JERSEY

EXECUTIVE OFFICES ☐ TWO PRINCESS ROAD, LAWRENCEVILLE, NEW JERSEY 08648 ☐ TELEPHONE 609-896-1766

Dear Fellow Member:

The MSNJ and my Committee on Retirement Plans for Physicians are pleased to announce a timely new retirement planning resource.

The HEALTH CARE GROUP and its Health Care Consulting, Inc. staff, attorneye and consultants exclusively to health care providers, now offer comprehensive, individually prepared retirement plans through a convenient MSNJ sponsorship and on a discounted fee basis.

Health Care Consulting plans accomplish three very important objectives in 1984 —

— assure your plans comply with TEFRA — as they must in 1984

— more importantly, increase your overall flexibility — more than 30 selective features designed specifically for physicians

— and add the power to choose your own investments — unavailable in most Keogh and corporate prototype plans

Health Care Consulting's plans have been specifically drawn and designed for physicians' personal and practice demands, to assure compliance with TEFRA and yet obtain maximum flexibility.

These plans* provide another valuable alternative to your existing plan choices, while maintaining the option to choose your own investments — unincorporated Keogh members for the first time, in fact.

In the thoughtful, descriptive material available** (by the enclosed card or toll-free number) Health Care Consulting has outlined the law's changes required in your 1984 fiscal year and these special features found so useful to physicians and medical practices.

We expect you will find these materials timely and informative as you evaluate your retirement plans in 1984.

Sincerely,

Nicholas E. Marchione

Nicholas E. Marchione, Chairman
Committee on Retirement Plans for Physicians

Enc.

*(money purchase, profit-sharing, defined benefit, 401(k), etc.)

**"Summary of Retirement Planning Under TEFRA"
"Discussion of Comprehensive Plan Features"
"Checklist To Review Your Retirement Plans"
(Physician's Management, March 1984)

is a pivotal year for retirement planning, with the challenges presented by TEFRA and the ortunity for individually drafted plans.

C is extremely pleased to work with MSNJ and has prepared informative material on **irement planning under TEFRA,"** **"comprehensive plan features,"** and a **"checklist to review r plans,"** available by phoning toll-free or writing —

h Care Group

cal Society of New Jersey/
h Care Consulting, Inc.
HE HEALTH CARE GROUP
Belmont Avenue
Cynwyd, PA 19004
-441-0737
567-2468

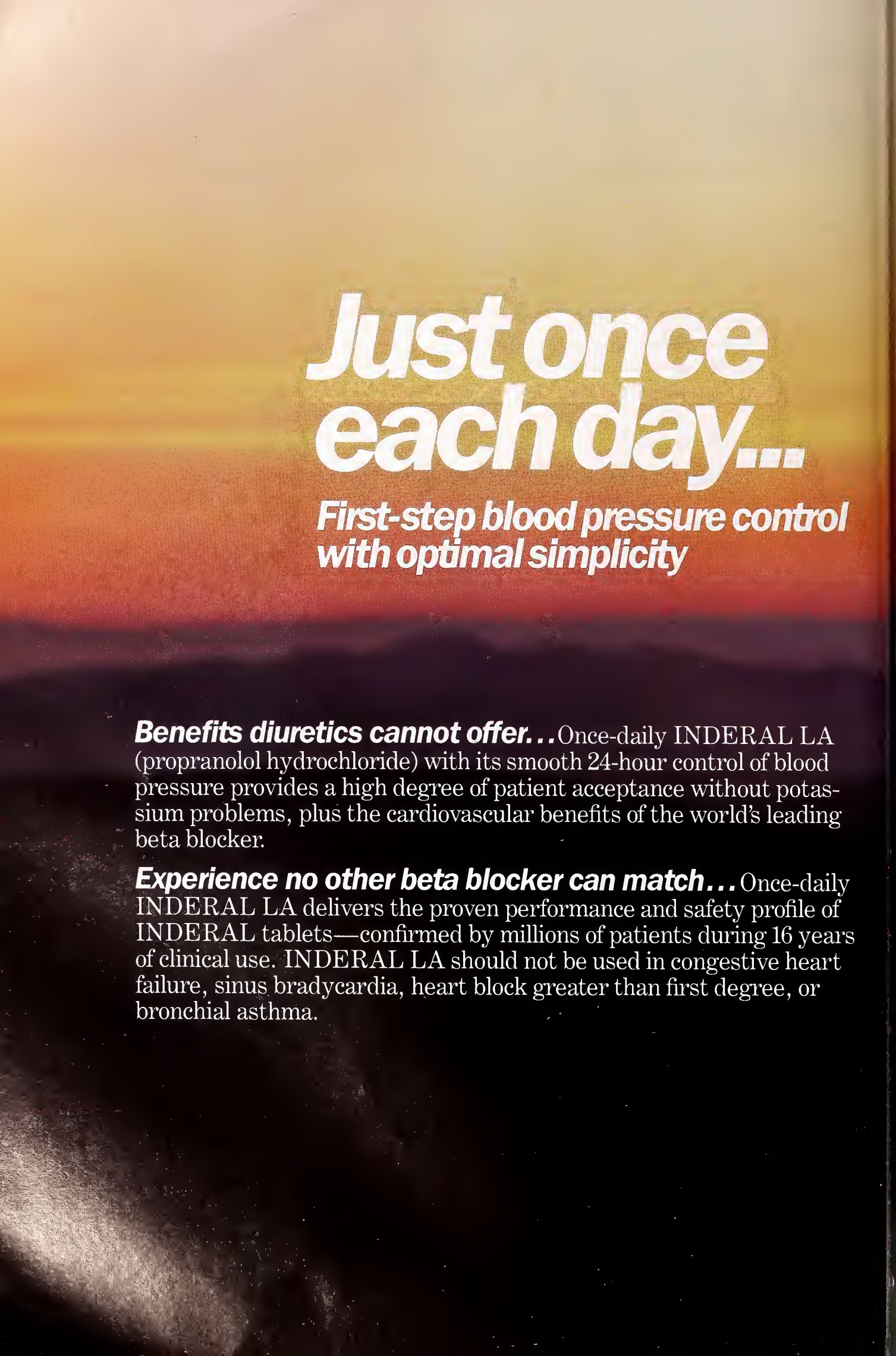
Name _____

Address _____

_____

Phone _____

Unincorporated ☐ Incorporated ☐ Fiscal year ends _____


Just once each day...
First-step blood pressure control with optimal simplicity
Benefits diuretics cannot offer... Once-daily INDERAL LA (propranolol hydrochloride) with its smooth 24-hour control of blood pressure provides a high degree of patient acceptance without potassium problems, plus the cardiovascular benefits of the world's leading beta blocker.
Experience no other beta blocker can match... Once-daily INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.



Start with 80 mg once daily... Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY INDERAL® LA

(PROPRANOLOL HCl) *LONG ACTING CAPSULES*



80 mg *120 mg* *160 mg*

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories

Ayerst

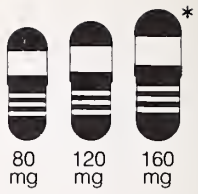
Just once each day for initial therapy in hypertension.

Just once each day for initial therapy in HYPERTENSION.

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking the prior to major surgery is controversial. It should be noted, however, that the impaired abil the heart to respond to reflex adrenergic stimuli may augment the risks of general anesth and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of t receptor agonists and its effects can be reversed by administration of such agents, dobutamine or isoproterenol. However, such patients may be subject to protracted se hypotension. Difficulty in starting and maintaining the heartbeat has also been reported beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the pearance of certain premonitory signs and symptoms (pulse rate and pressure change acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroid Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of sympt of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function t

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have b reported in which, after propranolol, the tachycardia was replaced by a severe bradyca requiring a demand pacemaker. In one case this resulted after an initial dose of 5 propranolol.

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impa hepatic or renal function. INDERAL is not indicated for the treatment of hyperten emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Pati should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart dise elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as re pine should be closely observed if INDERAL is administered. The added catecholam blocking action may produce an excessive reduction of resting sympathetic nervous act which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthost hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals h been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studie both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of signific drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dos levels. Reproductive studies in animals did not show any impairment of fertility that attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic animal studies at doses about 10 times greater than the maximum recommended human dc

There are no adequate and well-controlled studies in pregnant women. INDERAL sho be used during pregnancy only if the potential benefit justifies the potential risk to the fe

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised wh INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and h rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hy tension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomn lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; vis disturbances; hallucinations; an acute reversible syndrome characterized by disorientation time and place, short-term memory loss, emotional lability, slightly clouded sensorium, a decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrh constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with achi and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytoper purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has be reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male imp tence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactio involving the skin, serous membranes and conjunctivae reported for a beta blocker (practol have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride i sustained-release capsule for administration once daily. If patients are switched from INDER tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeu effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration m be necessary especially to maintain effectiveness at the end of the 24-hour dosing interv

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 m INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may b increased to 120 mg once daily or higher until adequate blood-pressure control is achieve The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 6 mg may be required. The time needed for full hypertensive response to a given dosage variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL L once daily, dosage should be gradually increased at three to seven day intervals until optimu response is obtained. Although individual patients may respond at any dosage level, th average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value ar safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few week (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL L once daily. The usual effective dose range is 160-240 mg once daily. The dosage may b increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is n obtained within four to six weeks after reaching the maximum dose, INDERAL LA therap should be discontinued. It may be advisable to withdraw the drug gradually over a period several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are to limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratorie

8950/28

Ayerst AYERST LABORATORIES
New York, N.Y. 10017

300 Years of Medicine in New Jersey

The Journal of the Medical Society of New Jersey with this special issue is honoring the knowledge and sophistication of its medical community.

"One measure of a civilized community could well be the extent of its acquired medical knowledge and sophistication." So states eminent New Jersey historian and author, David Cowen.

This issue of *The Journal* was conceived as a means of presenting to the citizens of New Jersey, both physician and layman, a history of the "healing art" in our state; for to understand where one is going, one must understand where one has been. The history of medicine often is viewed as the history of scientific misconceptions and quackery—that health professionals and their work are isolated from the rest of society. This issue we hope will dispel many of these erroneous myths as we present articles covering a broad spectrum of the "healing art." Articles reveal the contributions made to society by physicians outside of medicine, physicians who were involved in the political and military fight for independence, women who helped open the doors to equal opportunity in medicine, and crusaders for the rights, health, and safety of industrial workers and sailors.

In the realm of medical contributions, there are articles which discuss the early acquisition of medical knowledge by the Lenape Indians, the founding of our medical society (the oldest in the nation), the growth of the various aspects of health care, and some of the leading medical associations and personalities. Of particular use to researchers is the extensive bibliography of publications on the history of medicine in New Jersey.

The photographic section highlights the exhibits produced by the Middlesex County Cultural and Heritage Commission, the University of Medicine and Dentistry of New Jersey-Rutgers Medical School, and the Middlesex General/University Hospital, celebrating 300 years of medicine in New Jersey.

"300 Years of Medicine in New Jersey" is cosponsored by *The Journal* of the Medical Society of New Jersey and the Middlesex County Cultural and Heritage Commission. Publication was aided by a grant from the New Jersey Committee for the Humanities. Financial support was received from Sandoz, Inc., Merck, Sharpe & Dohme, Knoll Pharmaceutical Company, and Johnson and Johnson to help defray the costs of this special issue.

Morris H. Saffron, M.D., Guest Editor
Archivist-Historian, Medical Society of New Jersey and The Academy of Medicine of New Jersey
Stuart Sammis, Project Director
Archivist, University of Medicine and Dentistry
Arthur Krosnick, M.D., Editor
The Journal, Medical Society of New Jersey
Geraldine Hutner, Managing Editor
The Journal, Medical Society of New Jersey

Motrin®
ibuprofen, Upjohn
600 mg Tablets



More convenient for your patients.

Upjohn

©1984 The Upjohn Company

The Upjohn Company • Kalamazoo, Michigan 49001 USA

J-4044 January

The Lenape Contribution to New Jersey Medicine

Thomas P. Fitzpatrick, Teaneck*

The colonists and doctors of early New Jersey owe a debt to the original inhabitants of the state, the Lenape. The medicine plants and cures of the Lenape people left a legacy that can be found in our medical folklore, and it can be said the Lenape were the first medical practitioners and pharmacists in New Jersey.

The diversity of the Lenape people† scattered throughout New Jersey precludes stating a harmacopoeia known and used by all the different ands. The development of curative practices by indiiduals resulted in the application of a specific herb r different ailments, while the sacred aspects of some lants and their potential power made many Amerndian herbalists reluctant to share their acquired nowledge of specific plants with the colonists. As a esult of conflicts with the Europeans, the Lenape beame distrustful and resentful of the settlers' motives, nd hesitant to aid them with their medical expertise.

The herbal remedies of the Europeans and the merindian tribes they came into contact with altered he Lenape's pharmacopoeia by close association or ntermarriage with members of these groups. As the enape migrated westward, some new herbs in the new oras were included in their medical repertoire. The est source of information comes from the journals of he Swedish and Dutch colonists. Although some of heir leaders were interested in botany, and either decribed the plants used by the Lenape, or sent some f the plants to Europe for examination, many of the ettlers primarily were interested in acquiring land nd furs, and not the medicinal knowledge and asociative restorative practices of the local people.

The assertion that the colonists used many Lenape nedicine plants can be supported from the scanty references in the settlers' journals of Europeans being cured by Native American herbalists and by the early inclusion of many plants unknown in Europe in the recipe books kept by colonial housewives. These books often included notations such as "squaw remedy," often giving detailed directions on how to dispense the medicinals which paralleled Lenape usage.

Although the Europeans had a rich herbal folklore of their own, their plant supply was limited at first by the amount of dried material brought over on ships, or the successful germination of herbs from seeds. If their supply of medicine plants was cut off, they either had to locate plants similar to the ones they were familiar with in their homelands, or use trial-and-error or the "doctrine of signatures" to find an herbal cure for an illness. The "doctrine of signatures," which held that the shape or color of particular plants pointed the way to cures, was used by Europeans and Amerindians alike. Either of these alternatives was likely to be un-

*Thomas P. Fitzpatrick is an art teacher in the Teaneck Public Schools and a research associate of the Archaeological Research Laboratory at the Van Ripper-Hopper Museum in Wayne.

†Lenape or Lenni-Lenape were the names used by several closely related Amerindian tribes of the Algonquian branch of the Algonquian-Wakashan linguistic stock, who lived in what now is New Jersey, Delaware, Eastern Pennsylvania, and Southeastern New York. They were called the Delaware Indians by the early European settlers because they lived in the vicinity of the Delaware River.

successful or produce death by poisoning. In the event the plants were medically effective for a given complaint, the specific plant part that would produce the cure, the proper gathering season, the dosage, and method of preparation, and the application would have to be known to produce the desired result and avoid overdosing.

The Lenape assisted the early settlers on a number of occasions by giving them shelter, providing food, teaching them how to hunt, and how to procure wild foods and avoid poisonous ones. References also are available on native "doctors" using their remedies to cure the ailments of the early colonists. If the Europeans could not make use of their own pharmacopoeias, and if one of the handful of early doctors was not available or did not have access to the necessary medicinals, a Native American herbalist might be prevailed upon as a last resort to try to cure the patient.

Bit by bit, some of the indigenous plants and remedies found their way into the colonists' homes, supplanting, or used in conjunction with, their own herb lore, thereby providing an abundant source of medicine that did not have to be dearly paid for at a distant apothecary shop. Even after patent medicines readily became available from European and domestic sources, the Lenape remedies did not fall into disuse, but existed side by side with European remedies, being eventually included in the *United States Pharmacopoeia*, the *National Formulary*, and the *Dispensatory of the United States*.

EUROPEAN MEDICINE AND FOLK MEDICINE

Names of doctors were unusual on the passenger lists of ships laden with emigrants from the several European countries that anchored in New Jersey waters in the 1600s. As settlements began to prosper, a few doctors ventured to this wild land, but as the towns grew, the colonists searched out new land for farms, slowly extending their distance from the main settlements. In the 1600s, the 20 practitioners who were present in the colony were hardly able to be on call to all of the colonists who needed them, even if they were close enough to be reached or rich enough to afford their fees. Even if a doctor were within reach, the settlers often were reluctant to trust their treatments, which often as not were unsuccessful in curing their complaints.

In order to understand why the colonial doctors were not highly regarded, and why the leading physician of New York was listed among the "small citizens" in the town's census of 1657, it is necessary to understand the state of medicine in Europe at that time. The 1650 edition of the *London Pharmacopoeia* not only listed the moss growing in the exposed skulls of hanged criminals as being used for medicine, but the raspings of the skull itself. Another reference, the *Schroedero-Hoffmann Pharmacopoeia* of 1687, listed a formula for an electuary containing almost 50 ingredients, including such exotic materials as emeralds, sapphires, coral, pearls, and topaz. Even though the colonial doctors did not have access to many of the above materials, they improvised concoctions of their own. For example, Governor Winthrop's 1656 recipe for curing ulcers used crab eyes; John Winthrop, Jr.'s cure for the



Figure 1—Yarrow, *Achillea millefolium* (left) and Indi poke, *Veratrum viride* (right).

ague (intermittent fever with chills) consisted of pu ting the parings from a patient's nails into a bag tie around the neck of a live eel; Doctor Salmon's linime for sciatica in his 1710 *Family Dictionary* used amor other things, newly whelped puppies and earthworm

The disillusionment with the often unsuccessf cures offered by the practitioners of the time was con pounded by the ineptitude of the many unqualifie people who presumed to practice medicine witho any formal training, the dearth of accepted medicina necessary to treat the maladies, and the limite number of apothecaries available to prepare the ingr dients. Early attempts were made by the colony leaders to regulate the preparation of drugs and th practice of medicine, such as the Duke of York's a tempt to monitor apothecaries in New Jersey with pe alties for malpractice in 1664. But schools for th training of physicians were scarce even in Europe, an a method of regulating those who were practicing d not appear until New Jersey required the examinatic and licensing of physicians in 1772—the first provinc to do so.

This discussion explains some of the factors th necessitated the settlers' attempts to utilize the flo that surrounded them, especially the housewife, wh often was the one relied upon to cure her family medical problems. It should be remembered that th Europeans who came to New Jersey brought with the a rich folklore of plant remedies used by the ancestors. They found, growing in their new lan plants, such as yarrow (*Achillea millefolium*) an hoarhound (*Marrubium vulgare*), just as they had i their homelands, and they continued to use ther Other plants, such as Indian poke or false hellebo (*Veratrum viride*), blue flag (*Iris versicolor*), America ginseng (*Panax quinquefolius*), and American pe nyroyal (*Hedeoma pulegioides*), were similar to sp cies they knew in Europe, such as the European fal hellebore (*Veratrum album*), stinking iris (*Ir foetidissima*) and Florentine iris (*Iris germanica*), A atic ginseng (*Panax schin-seng*), and European pe nyroyal (*Mentha pulegium*). Since the American an related foreign species have the same essential co stituents, the emigrants could use the herb rootstock in the same amount and in the same w

s their forefathers had with predictable results (Fig-re 1).

UROPEAN CONTACTS WITH LENAPE ERBALISTS

In a number of colonial homes, the housewife kept collection of remedies or recipes to be used for vari-us illnesses in a commonplace book. This handy refer-nce was used in conjunction with, or in place of, nedical books, such as Salmon's *Herbal*, first pub-shed in England in 1676, or a *Collection of Receipts*, ublished in 1755 by Robert Eastburn of New Bruns-vick. Along with the medicinals known to European nedicine are references to "Indian's squaw" cures, and o plants unknown in Europe, which explain how to ollect the specific part of the plant to be used, the mount, and the manner of preparation and appli-ation. This type of folk knowledge was not developed n one person's lifetime by trial-and-error, but was the roduct of generations of experience.

While numerous books made reference to Euro-eans' using the Native American's medicinal herbs, ne above example of the "Indian squaw" cure only uggests that the settlers learned of remedies from the enape, or, as they often are referred to, the Delaware ndians. The journals of the early Swedish colonists long the Delaware River, and the notebooks of Dutch, wedish, English, and German men of science give us rst-hand accounts of some of the Lenape medicinals, nd of cures performed on Europeans.

When the Europeans first arrived in New Jersey, the enape were not a cohesive or tribal unit. Native Ameri-ans were members of different autonomous groups, who did not represent the intentions or interests of all ne Lenape people. Nevertheless, many of the Euro-eans were treated cordially by these separate groups. he Dutch settlement at Bergen, begun by Danish or orwegian emigrants around 1618, was allowed to rosper and friendly relations ensued; in 1649, the wedes obtained land on the New Jersey side of the elaware River, established settlements, and were armly greeted by the inhabitants. During the fall of 677, the English settlers who landed in the Bur-ngton area were ill prepared for the winter, so the ative Americans gave them food and shelter to urvive.

Although some early hostilities had occurred in East ersey, the Lenape never again trusted the Dutch after ne massacre of 80 Native Americans in Pavonia (Jer-ey City) in 1643. As the English obtained more and nore of their former hunting grounds, the Amerin-ians retreated farther away from the colonial settle-nents, continuing to barter, but becoming more dis-rustful of the settlers' motives. The Swedish were the nly group who continued to maintain friendly rela-ions with the Lenape. A number of the Swedes learned he Lenape language, tried to convert them, and acted s interpreters for the English Quakers.

Due to the secrecy with which many Native Ameri-an herbalists treated most of their medicinal plants, is fortunate that we are able to identify any of the pecies utilized by them. Since the Lenape lived in cattered groups without a central government, no harmacopoeia or medical society existed to ensure that medicinal knowledge of herbs and curative practices would be available to all herbalists. Any specialized knowledge that an individual practitioner acquired was considered as a sacred trust not to be openly shared with the uninitiated due to the powerful nature of many of the agents. Despite these conditions, it appears that some plant remedies were known and used by the average Native Americans in the same way that we use aspirin and witch hazel. The plants that we know were used in specialized cures, however, either must have been observed by the early settlers or shown to them by native herbalists.

Some of the plants used by the Lenape for medicine can be found in accounts such as *The Representation of New Netherland*, 1650, by Adriaean van der Donck, a Dutchman who was the patroon of present-day Yonkers and who praised the Amerindians' use of local plants for various illnesses. Gabriel Thomas, an English Quaker with the first group of William Penn's emigrants, mentioned some of the herbs and roots used by the Lenape, and the ailments they were used for, around 1680 in his *An Historical and Geographical Account of Pensilvania and of West-New Jersey*. In *The Journal of Andreas Hesselius, 1711-1724*, the Reverend Hesselius, Swedish pastor of Holy Trinity in Wilmington, New Sweden, described instances of the Native Americans sharing their medical knowledge with the early settlers. He related how his son was purged of parasitical worms by a woman herbalist, and how his servant was cured of a severe case of poison sumac by the use of a bark medicine.

The accounts of scientists and doctors also provide valuable information on the medicinals of the Lenape in New Jersey. Peter Kalm, a Swedish-Finnish naturalist, visited the former colony of New Sweden in 1750. In his *Travels in North America*, 1748 to 1751, he gave a detailed and scientific description of American natural phenomena. Although most of the Native Americans had moved from the areas he visited, he obtained information about Native American herbal cures from a number of the old Swedes who had been treated by the Amerindians. Dr. Johann David Schopf, a Hessian physician of the British Army who remained in America after the American Revolution, gave a picture of the medicines of that time in a narrative of his travels. Partial to the drugs of the New World, he wrote the first *Materia Medica Americana* in 1787, which included many of the Native American medicinals.

When the Lenape began their westward migration, the Moravian missionaries recorded their curative practices and medicine plants. John Heckewelder, whose observations are recorded in the *History, Manners, and Customs of the Indian Nations Who Once Inhabited Pennsylvania and the Neighboring States*, worked among the Delaware in Pennsylvania and Ohio from 1762 to 1786. An associate of Heckewelder, David Zeisberger, worked among the Delaware in Pennsylvania, Ohio, and Canada from 1767 to 1808. His *History of the North American Indians* provides reliable information on the flora of the regions, describing in detail many Native American medicinals. Another missionary, George Henry Loskiel, collected the Amerindians' herb cures noted by other United Brethren ministers from 1735 to 1787 in his *History of the Mission of the United Brethren among the In-*

dians of North America in 1794.

In 1821 to 1822, General Lewis Cass, Governor of Michigan Territory, collected information through government agents and others in contact with the Delawares and Monsies by using a questionnaire entitled: *Inquiries, Respecting the History, Traditions, Languages, Manners, Customs, Religions & c. of the Indians, Living Within the United States.* He engaged Charles C. Throwbridge as his private secretary and assistant, and the two of them prepared manuscripts based on data supplied by Delaware informants in Ohio and Canada. Although the manuscripts do not mention specific medicinals, they do show that some of the curative practices noted in the Lenape's eastern homeland remained essentially intact.

A comparison of the accounts of the early settlers, scientists, and doctors in the New Jersey area with the migration observations of the Moravian missionaries and the inquiries of Cass and Throwbridge all tend to indicate that much of the medicinal knowledge of the Lenape recorded outside of New Jersey probably originated in the state. The enduring strength of oral tradition in preserving the cumulative knowledge of the past makes it necessary to consider seriously much of the information provided by the 20th century Delaware informants. Herbalists, such as Wi-tapanoxwe, one of the last Delaware men from Dewey, Oklahoma, to prescribe herb cures, passed on a wealth of traditional medicinal herbs and curative practices when interviewed in 1930. Nora Thompson Dean, also from Dewey, Oklahoma, now in her early 70s, is one of the last Delaware traditionalists. She made up a list of medicinals used in Oklahoma that is similar to Witapanoxwe's. Even though more than 300 years of cultural intermixing and changing flora undoubtedly have altered the Lenape's pharmacopoeia, a study of the information provided by these 20th century informants gives us a glimpse of the materia medica that once existed in New Jersey.

IMPACT OF SPECIFIC LENAPE MEDICINALS

The plants used by the Lenape and the early colonists eventually became incorporated in the standard medical references of the United States.

Two medicinal plants known to have been used by the Lenape living in the New Jersey area are wormseed (*Chenopodium ambrosioides*) and lady slipper or moccasin flower (*Cyprepedium ocuale*). Wormseed, used by herbalists as an effective agent against intestinal worms, also was used by Swedish settlers in New Jersey and Pennsylvania in 1750 to rid children of the parasites. C.A. Weslager has remarked that this possibly was the same plant that a woman herbalist used to cure Reverend Hesselius's two-year-old son when he was wasting away from worms between 1712 and 1723. Many doctors in the 1800s used wormseed oil as an effective remedy against roundworms, and it became listed officially in the *United States Pharmacopoeia* from 1820 to 1947, and in the *National Formulary* from 1947 to 1960. The 1973 *Dispensatory of the United States* reports that although the oil is one of the most effective drugs against roundworm and hookworm, it has been superseded by less toxic anthelmintics.

Lady slipper was noted as a native medicinal by van der Donck in the 1600s and by Kalm in the 1700 Kalm wrote that a decoction of the root was effecti for women in labor, and doctors in the 1800s used as a sedative to quiet spasms of voluntary muscles ar hysterical attacks. The roots were official in the *Unite States Pharmacopoeia* from 1863 to 1916 as an an spasmodic and as a nerve medicine. Its usefulness l in its lack of narcotic or side effects, but it now h been replaced by synthetic agents.

Another pair of plants, the tulip tree (*Liriodendr tulipfera*) and the butternut or white walnut (*Juglai cinerea*), are examples of medicinals not used e clusively by herbalists, but known and employed by t average Lenape. The bark of these trees was utiliz for medicine not only in New Jersey, but during t westward migration as well. Dr. Eric Stone states th the Lenape used a decoction of the fruit and the ro bark of the tulip tree as a febrifuge, and Kalm in 17 recorded the Swedish settlers' use of the root bark treat fevers, and the crushed leaves applied to the for head for headaches. Loskiel noted the migrati Lenape's use, between 1735 and 1787, of the fruit ar root bark to treat ague. Long used in domestic mec cine, the bark was official in the *United States Pha macopoeia* from 1820 to 1888 for its tonic ar diuretic properties, and the *Dispensatory of the Un ed States* reports that the bark also was useful treating rheumatism and digestive problems.

The butternut had been used in American medici since before the Revolutionary War as a laxative, ar Doctor Barton, an 18th century Philadelphia phys cian, used butternut for its purgative, anodyne, ar blistering properties. A home remedy for raising blister, from the commonplace book of the Hankinsc family of Reading, begun about 1787, gives directio on how to collect the bark, the amount to be used, i preparation, and its application. Butternut bark pi were used in one of the cures prescribed by Pet Smith in the late 1700s. Smith described both himsc and his father, Hezekiah Smith, who lived in New Je sey, as "Indian doctors," since most of their remedi were used by the Native Americans. Zeisberger ar Loskeil noted that the 18th century Lenape on the westward trek used the bark as a styptic on fres wounds to relieve pain, prevent swelling, and accelera healing. The inner root bark was official in the *Unite States Pharmacopoeia* from 1820 to 1905 for its la ative and tonic effects (Figure 2).

Some plants, such as the bayberry (*Myrica pen sylvanica*), skullcap (*Scutellaria laterifolia*), Amer can elm (*Ulmus americana*), and slippery elm (*Ulm fulva*) have been documented as being used not or in the New Jersey area by the Lenape, but also Oklahoma, the western terminus of the migration f a large number of the tribe. The use of the bayber for medicinal purposes was noted by Kalm in 1748 1750, when an old Swedish settler informed him th the Native Americans showed him how to use the ro for a toothache remedy. Doctor Barton, in 1803, r corded the bayberry's use as an astringent, f nephritis, kidney stones, and gonorrhea, while the wa from the berries was used to cure dysentery. The ba was official in the *United States Pharmacopoeia* fro 1820 to 1936 for its astringent and tonic propertie and in the *National Formulary* from 1936 to 1950. W



ure 2—Skullcap, *Scutellaria lateriflora* (left) and bayberry, *rica pennsylvanica* (right).

anoxwe reported the root as having curative powers the female generative organs, as well as being used a blood purifier and for kidney trouble.

)r. Lawrence Vandeveer of Somerset, one of the nders of the Medical Society of New Jersey, ex- imented with Native American medicinals and gan using skullcap in 1772. Vandeveer used skull- successfully to treat hundreds of patients suffering m hydrophobia or rabies, earning skullcap the fix of "mad dog." The proceedings of the Essex unty Medical Society in 1823 recorded that a mber of patients were saved by this remedy. The ed herb became official in the *United States Phar- acopoeia* in 1863, where it was listed until 1916 for sedative and antispasmodic properties. The Okla- ma Delaware, according to Wi-tapanoxwe, used the nt top as a laxative and a stomach stimulant.

The bark of the American elm and slippery elm has same medicinal properties, and was used by doc- s during the American Revolution to treat gunshot unds. Used for its demulcent and emollient perties, slippery elm bark was official in the *United ates Pharmacopoeia* from 1820 to 1936 and in the *tional Formulary* from 1936 to 1960. Accounts of n bark being used by the Delaware in Oklahoma ve been given by Wi-tapanoxwe, who used American n bark for coughs and colds, and Nora Thompson an, who claimed that the bark was effective in stop- ng coughs and relieving chills.

For a few species, Lenape usage can be documented the way from New Jersey, through Pennsylvania, io, and into Oklahoma. Sassafras (*Sassafras bidum*), flowering dogwood (*Cornus florida*), and rginia snakeroot (*Aristolochis serpentaria*) are ex- mples of medicine plants that have followed the long gration. Sassafras had been noted as an Amerindian edicinal in the New Jersey area by van der Donck in 50, and by Thomas in 1698, who recommended it a cure for venereal disease. New Jersey's colonists ed the root in the 1700s. Kalm was told by Swedish ttlers that the Native Americans used the plant for eating sore eyes, and Loskiel recorded the berries ing used as medicine by the Lenape east of the Mis- ssippi River between 1735 and 1787. The root bark as official in the *United States Pharmacopoeia* from 20 and 1926, when its oil, safrole, was used for its ntiseptic and pain relieving properties. The 1955 *Dis- pensatory of the United States* reports that a hot in- fusion of the bark was once a popular remedy as a sudorific for colds, and was recommended for disinfec- tion of root canals in dentistry and for nasal catarrhs. The plant also was popular in Great Britain, where a remedy known as Godfrey's cordial, made by mixing sassafras and opium, was listed in the *National Form- ulary IV* in 1722. Both Wi-tapanoxwe and Nora Thompson Dean listed sassafras among the med- icinals of the Oklahoma Delaware. They used the bark in a tonic to thin the blood, and so reduce high blood pressure.

The root bark of the flowering dogwood was con- sidered effective in treating malaria by Swedish set- tlers in the former colony of New Sweden in 1750. In the second half of the 1700s, the Moravian mission- aries Zeisberger, Heckewelder, and Loskiel, who all worked among the Lenape during their westward mi- gration, claimed that the natives boiled the inner bark in water to make a tea used to reduce fevers. Although it was official in many editions of the *United States Pharmacopoeia*, it now is only considered as a mild astringent. Wi-tapanoxwe, in 1930, reported that the Oklahoma Delaware used the root to make a tonic.

Virginia snakeroot, like sassafras, was another Native American medicinal sent to, and utilized in Great Britain, where it was official in the *London Phar- macopoeia* of 1650 as a remedy against the poisonous effects of snake bite; van der Donck listed it as a med- icinal in that same year in New Netherlands. It became a popular colonial remedy in the 1700s in New Jersey, while at the same time being used by the Lenape east of the Mississippi, according to Loskiel, as a sudorific and stomachic. Visiting royalty Prince Maximilian of Wied was shown the plant while staying at the Dela- ware Gap in 1832, and was told that the inhabitants used it as a styptic on wounds. It was official in the *United States Pharmacopoeia* from 1820 to 1942 and the *National Formulary* from 1888 to 1955 for its tonic and stimulant properties. The Oklahoma Dela- ware, according to Wi-tapanoxwe, used the root for its tonic qualities (Figure 3).

CONCLUSION

The plants described indicate the debt the colonists and doctors of early New Jersey owed to the original inhabitants of the state. The medicine plants of the



Figure 3—Flowering dogwood, *Cornus florida* (left) and sassafras, *Sassafras albidum* (right).

Lenape served the Europeans as well as they had their predecessors, and paved the way for further experimentation with indigenous species, many of which eventually were incorporated into our materia medica. Even though the Lenape have all but migrated from the state, they have left a legacy of medicinal plants and cures that today can be found not only in the few natural plant substances still used in pharmaceuticals, but in the folklore of mixed groups, such as the Sand Hill Indians and the Ramapo Mountain People of New Jersey.

The Sand Hill Indians were composed of Lenape who never had migrated and Cherokee families who had come from North Carolina in the early 1800s. They lived near Asbury Park in Monmouth County from 1877 until recent times, and several plants that a Native American informant claimed were used for herbal cures also have been reported as being used by the Lenape in Oklahoma. The list of herb cures and folk remedies used by the group of people of mixed racial ancestery that live in Ringwood and neighboring towns, as recorded by David Steven Cohen in *The Ramapo Mountain People*, also contains plants used by the Oklahoma Delaware.

The use of sassafras, Virginia snakeroot, slippery elm, and flowering dogwood by these contemporary people does not prove that the remedies are of Lenape origin, but simply indicates the continued existence of herb cures that have been assimilated into the diverse cultures that populate the state. Even if it is impossible to prove exactly which of all the native cures originated with the Lenape, it safely can be said that the inhabitants of the state, before the coming of the Europeans, were the first medical practitioners and pharmacists of New Jersey.

REFERENCES

1. Barber JW: *Historical Collections of New Jersey: Past and Present.* Spartanburg, SC, Reprint Co., 1868.

2. Benson AB, Hedin N: *Americans From Sweden.* Phila- phia, PA, J.B. Lippincott Co., 1950.

3. Brown AC: *Early American Herb Recipes.* Rutland Charles E. Tuttle Co., 1966.

4. Cohen DS: *The Ramapo Mountain People.* New Br wick, NJ, Rutgers University Press, 1974.

5. Cohen DS: *The Folklore and Folklife of New Je* New Brunswick, NJ, Rutgers University Press, 1983.

6. Cowen DL: *Medicine and Health in New Jersey: A tory.* Princeton, NJ, D. Van Nostrand Co., 1964.

7. Cowen DL: *Medicine in Revolutionary New Je* Trenton, NJ, New Jersey Historical Commission, 1975.

8. Heckewelder J: *History, Manners, and Customs o Indian Nations Who Once Inhabited Pennsylvania and Neighboring States.* Philadelphia, PA, Historical Societ Pennsylvania, 1876.

9. Kalm P: *Peter Kalm's Travels in North America.* York, NY, Dover Publications, 1937.

10. La Wall CH: *The Curious Lore of Drugs and Medi* Garden City, NY, Garden City Publishing Co., 1927.

11. Newcomb WW Jr: The Culture and Acculuration o Delaware Indians. *Anthropological Papers*, No. 10, Ann Ar MI, Museum of Anthropology, University of Michigan, 1

12. Stone E: *Medicine Among the American Indians.* York, NY, Hafner Publishing Co., 1962.

13. Tantaquidgeon G: *A Study of Delaware Indian M cine Practice and Folk Beliefs.* Harrisburg, PA, Histor Commission, 1942.

14. Thomas G: An historical and geographical accoun Pensilvania and of West-New Jersey (1689), in Myers AC *Narratives of Early Pennsylvania, West-New Jersey Delaware, 1630-1707.* New York, NY, Barnes and Noble, 1

15. van der Donck A: The Representation of New Net lands (1650), in Jameson JF (ed): *Narratives of New Net land.* New York, NY, Charles Scribner Sons, 1909.

16. Vogel VJ: *American Indian Medicine.* Norman, University of Oklahoma Press, 1970.

17. Weiner, MA: *Earth Medicine—Earth Food.* New Y NY: Macmilliam Publishing Co., Collier Books, 1980.

18. Weiss HB: *Life in Early New Jersey.* Princeton, NJ Van Nostrand Co., 1964.

19. Weslager CA: *Magic Medicines of the Indians.* Som set, NJ, Middle Atlantic Press, 1973.

20. Weslager CA: *The Delaware Indian Westward Mig tion.* Wallingford, PA, Middle Atlantic Press, 1978.

21. Zeisberger D: *History of North American Indians.* umbus, OH, State Archeological and Historical Society, 19



Nothing else can take its place.

INDERAL®
(PROPRANOLOL HCl)

Please see next page for brief summary of prescribing information.

Ayerst®

Nothing else can take its place.

INDERAL®
(PROPRANOLOL HCl)



10 mg 20 mg 40 mg 60 mg 80 mg 90 mg*

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

INDERAL® (propranolol hydrochloride) Tablets

CLINICAL PHARMACOLOGY

The Beta-Blocker Heart Attack Trial (BHAT) was a National Heart, Lung and Blood Institute-sponsored multicenter, randomized, double-blind placebo-controlled trial conducted in 31 U.S. centers (plus one in Canada) in 3,837 persons without history of severe congestive heart failure or presence of recent heart failure; certain conduction defects, angina since infarction, who had survived the acute phase of myocardial infarction. Propranolol was administered at either 60 or 80 mg t.i.d. based on blood levels achieved during an initial trial of 40 mg t.i.d. Therapy with INDERAL, begun 5-21 days following infarction, was shown to reduce overall mortality up to 39 months, the longest period of follow-up. This was primarily attributable to a reduction in cardiovascular mortality. The protective effect of INDERAL was consistent regardless of age, sex or site of infarction. Compared to placebo, total mortality was reduced 39% at 12 months and 26% over an average follow-up period of 25 months. The Norwegian Multicenter Trial in which propranolol was administered at 40 mg q.i.d. gave overall results which support the findings in the BHAT.

Although the clinical trials used either t.i.d. or q.i.d. dosing, clinical, pharmacologic and pharmacokinetic data provide a reasonable basis for concluding that b.i.d. dosing with propranolol should be adequate in the treatment of post-infarction patients.

CLINICAL: In the BHAT, patients on INDERAL were prescribed either 180 mg/day (82% of patients) or 240 mg/day (18% of patients). Patients were instructed to take the medication 3 times a day at mealtimes. This dosing schedule would result in an overnight dosing interval of 12 to 14 hours which is similar to the dosing interval for a b.i.d. regimen. In addition, blood samples were drawn at various times and analyzed for propranolol. When the patients were grouped into tertiles based on the blood levels observed and the mortality in the upper and lower tertiles were compared, there was no evidence that blood levels affected mortality.

PHARMACOLOGIC: Studies in normal volunteers have shown that a 90 mg b.i.d. regimen maintains beta blockade at, or above, the minimum for 60 mg t.i.d. dosing for 24 hours even though differences occurred at two time intervals. At 10-12 hours after the first dose of the day, t.i.d. dosing gave more beta blockade than b.i.d. dosing, at 20-24 hours the trend of the relationship was reversed. These relationships were similar in direction to those observed for plasma propranolol levels (see Pharmacokinetics).

PHARMACOKINETIC: A bioavailability study in normal volunteers showed that the blood levels produced by 180 mg/day given b.i.d. are below those provided by the same daily dosage given t.i.d. at 10-12 hours after the first dose of the day but above those of a t.i.d. regimen at 20-24 hours. However, the blood levels produced by b.i.d. dosing were always equivalent to or above the minimum for t.i.d. dosing throughout the 24 hours. In addition, the mean AUC on the fourth day for the b.i.d. regimen was about 17% greater than for the t.i.d. regimen (1,194 vs. 1,024 ng/ml• hr).

CONTRAINDICATIONS

INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS

CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely; or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS.

INDERAL (propranolol hydrochloride) should be administered with caution since it ma bronchodilation produced by endogenous and exogenous catecholamine stimulation receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking ther prior to major surgery is controversial. It should be noted, however, that the impaired a the heart to respond to reflex adrenergic stimuli may augment the risks of general ane and surgical procedures.

INDERAL, like other beta blockers, is a competitive inhibitor of beta-receptor agoni its effects can be reversed by administration of such agents, e.g., dobutamine or isop terenol. However, such patients may be subject to protracted severe hypotension. Dif starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the app ance of certain premonitory signs and symptoms (pulse rate and pressure changes) hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. fore, abrupt withdrawal of propranolol may be followed by an exacerbation of sympto hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have b reported in which, after propranolol, the tachycardia was replaced by a severe brady requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS

General: Propranolol should be used with caution in patients with impaired hepatic or function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patien should be told that INDERAL may interfere with the glaucoma screening test. Withdra lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart di elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as pine should be closely observed if INDERAL is administered. The added catecholami blocking action may produce an excessive reduction of resting sympathetic nervous which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or or static hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals been conducted to evaluate toxic effects and carcinogenic potential. In 18-month stud both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of cant drug-induced toxicity. There were no drug-related tumorigenic effects at any of th age levels. Reproductive studies in animals did not show any impairment of fertility tha attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in studies at doses about 10 times greater than the maximum recommended human dos

There are no adequate and well-controlled studies in pregnant women. INDERAL sh be used during pregnancy only if the potential benefit justifies the potential risk to the f

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Most adverse effects have been mild and transient and have rarely required the withdr therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; h sion; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually o Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insom lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; v disturbances; hallucinations; an acute reversible syndrome characterized by disorient for time and place, short-term memory loss, emotional lability, slightly clouded sensori and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrh constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male imp tence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reacti involving the skin, serous membranes and conjunctivae reported for a beta blocker (p lol) have not been associated with propranolol.

*The appearance of INDERAL tablets is a registered trademark of Ayerst Laboratorie

8965/28

Ayerst® AYERST LABORATORIES
New York, N.Y. 10017

A Sketch of Medicine in New Jersey to 1825

Morris H. Saffron, M.D., Lawrenceville*

New Jersey has contributed greatly to the medical history of this country. A brief sketch of the contributions by New Jerseyans from 1664 to 1825 is presented.

When the English seized New Netherlands in 1664, the territory now known as New Jersey already had been very sparsely settled by Swedes in the Delaware Valley, by Dutch on the Hudson, and by English on Newark Bay. Almost immediately, James, Duke of York (later James II) conveyed proprietorship of the province to his friends, Lord John Berkeley and Sir George Carteret; the subsequent division of the region into Calvinist East Jersey and Quaker-dominated West Jersey was to produce lasting effects on the political, economic, and cultural development of the two areas. Even when the united province eventually attained its own royal governor (1738), the legislature, catering to mutual mistrust and public bickering, agreed to meet in alternate years at Amboy and Burlington.

MEDICAL LEGISLATION

Medical legislation in the province dates back to the Duke of York Law (1665) intended "to restrain the presumptuous from expressing power contrary to the approved rules, without the advice of those studied in the art or the consent of the patient." Although couched in stern language, this law had practically no effect on the charlatans who insisted on entering into the practice of medicine at their own pleasure.

One authority claims that between 1680 and 1690 members of the medical profession held legal title to one-quarter of the land in the present state of New Jersey; certainly from 1692 to 1697, medically trained Andrew Hamilton was entrusted with the governorship of the entire province, during which time he established the first successful postal system in America. In respect to medical control, however, it should be noted that as early as March 1705, Governor Richard Ingoldsby issued the following license at Burlington: "To Richard Smith, gentleman, Greeting. Being well informed of your knowledge, skill, and judgment in the practice of chirurgery and physic, I do hereby license and authorize you to practice the said science of chirurgery and physic within this her Majesty's province of New Jersey."

In May 1705, the Governor issued a similar license to Nathaniel Wade and it was this benevolent character who distilled medicines for gratuitous use among the poor immigrants pouring into West Jersey.

CONDITIONS IN NEW JERSEY

Early settlers were uniform in their praise of the beauty of the province, comparing favorably the temperate climate of New Jersey with the bitter cold winters of New England and the sulphurous summer heat of Virginia. Indeed, in spite of two early, devastating epidemics of smallpox or measles, recorded as early as 1638 and 1641 in West Jersey, Charles Gordon of Woodridge wrote discouragingly to his well-trained physician brother in Scotland (1685): "If you desire to

*Dr. Saffron, Archivist-Historian of the Medical Society of New Jersey, is Guest Editor of this issue.

come hither yourself, you may come as a planter, or a merchant, or as a doctor of medicine. I cannot advise you as I can hear of no diseases to cure, but some agues and cutted fingers, but there is no want of empiricks for these already. I confess that you could do more than any yet in America, being versed in chirurgery and pharmacie, for here are abundances of herbs, shrubs, and trees, and no doubt ones for making drugs, but there is little imployment in this way."

By the year 1700, the population of the province did not exceed 20,000. One estimate places the number of practitioners at this period at 20. In several counties, Camden, for example, not a single trained physician was to be found.

The instruction of medicine in New Jersey was handed down from generation to generation.

As time went on, the early euphoria about the unusual healthfulness seemed to disappear as Europeans brought with them not only smallpox, but measles and venereal disease, while the swamps and stagnant waters of Jersey spawned epidemics of malaria (ague) and yellow fever. In 1714, measles again assumed alarming proportions in Salem, and one observer wrote "We had a sickly time this year. I buried more than in ten years before." Smallpox was prevalent in both Jerseys in 1716 and was so severe in Burlington that the Assembly transferred its work to distant Crosswick. Fifteen years later, yellow fever imported from Philadelphia caused the cancellation of the annual Burlington Fair. The procedure of inoculation, introduced into this country in 1721 by Zabdiel Boylston of Boston, was supported strongly by the Reverend Cotton Mather and this encouraged its ready acceptance by the theologian-physicians who made up the bulk of practitioners of East Jersey. As early as 1732, we learn that "smallpox spreads very much in New Jersey at Amboy, New Brunswick, and there away. Many have been inoculated and not one of them has died, but have had the distemper very easy."

However, the most malignant and frightening epidemic of all began in a small New Hampshire village in 1735 and spread rapidly through New England to reach New Jersey later in the same year. Called the "throat distemper" it first was described by the Reverend Jonathan Dickinson of Elizabethtown who practiced medicine for almost three decades and whose circuit extended to the Orange Mountain area: "The long continuance and universal spread of this distemper among us has given me abundant opportunity to be acquainted with it in all its forms. The first assault was in a family about ten miles from here which proved fatal to eight of the ten children in about a fortnight. Being called to visit the distressed family, I found upon my arrival one of the children newly dead, which gave me the advantage of a dissection and thereby a better acquaintance with the disease than I otherwise could have had." The description which follows clearly identifies diphtheria as the culprit, almost century before the Frenchman Bretonneau finally ga the entity its present name. Even Dickinson's su gested treatment seems rational for the period: "Tak some honey and the sharpest vinegar, with alum di solved therein, and let the patient often gargle it i their throats; or if they be children, then take a feath and dip it into said liqueur and so wash their throats

NEW JERSEY PHYSICIANS

Dickinson also is famous as the founder and firs president of the College of New Jersey (Princeton) i 1747. Tragically, he contracted a virulent form smallpox following inoculation from which he su cumbed. Dickinson was representative of the ministe physician, many of whom found it necessary to pra tice medicine in order to support their families. Th most learned member of the community, the ministe served not only as spiritual head, but also as healer the body. Having familiarized himself with the cor tents of such standard medical texts as Sydenhar Culpepper, and Salmon, the minister-physician wa well able to play this double role until long after th mid-century when he gradually was superseded by full time practitioners. To anticipate, we may note that o the 17 doctors who met in 1766 to organize the Medi cal Society of New Jersey, no fewer than 6 were me of the cloth and the group unanimously elected as firs president, Reverend Robert McKean of Amboy.

In Quaker-dominated West Jersey, physicians in cluded several well-trained men of education an means, frequently of Scottish or Welsh origin. Bein business-oriented, they often supplemented their pro fessional revenues by turning to agriculture, merchan dising, and real estate ventures. Such a man was th learned Doctor Thomas Cadwallader, a resident o Philadelphia who owned considerable property in th Trenton area, and he became the first burgess of th borough in 1746. Upon his retirement in 1750, h donated 500 pounds for the establishment of a public library in the town. His famous essay on the "Dr Gripes" or lead poisoning in the West Indies, dated a Trenton, March 25, 1745, shows his intimate connec tion with our state.

A notable foreign observer of the period was th Swedish physician, Peter Kalm, who spent 1747 an 1748 studying the health of his countrymen settled in the region of Penn's Neck and Swedesboro. He noted an epidemic form of "pleurisy" (pneumonia) which decimated the older population. He attributed the early loss of teeth among the Europeans to the excessive use of tea; and observed the presence of a severe bloody flux or dysentery endemic, and often fatal, among the young people who also suffered from a rapid form o consumption. Kalm mentioned the presence of a town physician in the various communities who was paid to take care of the elderly and indigent.

Other outbreaks of the period listed by John Duffy included: Oyster Bay measles, 1730; Burlington flux, 1734; malaria when one missionary was "baited to death with Muscatoes and Goluppers which did not let him rest night and day," 1738; Burlington yellow fever, 1744; Perth Amboy smallpox, 1746; Elizabethtown influenza, 1748; Perth Amboy smallpox, 1756; and influenza and typhoid, 1760s.

EDICAL CARE

n the more isolated areas of the province, "kitchen-ysick" virtually was a necessity because of the infre-ency of qualified practitioners. It was in these lo-tions that the women of the community brewed their rbal concoctions or "Indian squaw cures" and took re of the assorted ailments.

n New Jersey, community instruction in medicine nost was obtained exclusively through the system of prenticeship, by which an intelligent youth, with me preliminary education and aptitude, would bind mself for a period ranging from four to seven years an older physician. Aside from learning to bleed and p, he was taught to prepare and dispense drugs, to t bones and dislocations, to treat burns and arrow d gunshot wounds, to reduce hernias, and probably inoculate against smallpox. He also might encounter al cases of toadstool poisoning, rattlesnake bites, d rabies, or read about them in lurid accounts in e weekly press. In many instances intimacy of the prentice with the physician's family led to marriage th one of the preceptor's daughters, and subsequent rtnership. At any rate, on departure he usually was esented with "a new set of surgeon's pocket instru-ents" and several books.

With instruction in medicine being handed down m generation to generation it is not surprising that milies" of doctors persisted in New Jersey through-t this early period. Prominent among these groups re the Blachlys, the Budds, the Elmers, and the ersons, each producing six or more physicians over e years.

With the opening of Princeton College (1747) and ueens College (1766), standards for entering on a edical apprenticeship were raised considerably, and knowledge of Latin and even Greek later was ex-cted of the applicant. Although neither of these stitutions gave medical courses, their presence on rsey soil raised the general level of education and imulated an interest in science on the part of their raduates inducing many to enter the medical pro-ssion. Princeton and Queens had the right to confer e medical degree by virtue of their royal charter.

The French and Indian War (1755 to 1763) brought New Jersey an opportunity for advances in surgery. lthough no fighting took place in the province itself, ore than 1,000 Jersey Blues fought in the northern mpaign from 1758. The construction of stone army arracks in Burlington, New Brunswick, Amboy, Tren-n, and Elizabethtown brought well-trained English urgeons who were willing to discuss medical matters ith civilian physicians or to impart their knowledge their surgical mates. As early as 1752, one surgeon, homas Wood, advertised at New Brunswick the first ourse of "osteology and myology" to be held on Jersey oil, but it seems doubtful whether the lectures ever ere given. Surgery benefited as a result of this war xperience. Operations now included fistula in ano, nd especially "cutting for the stone," since calculosis as prevalent among settlers of English ancestry. One elebrated lithotomy was performed in Newark before select audience by the famous New York military urgeon, John Jones, as early as 1767. The usual harge for this procedure was five pounds.

Among the many Americans who profited by contact with the British surgeons was another celebrated inoculator, John Cochran, a native of Pennsylvania, who married the sister of General Philip Schuyler of Albany and settled in New Brunswick after the war (1793).

During the French and Indian War, smallpox again had become epidemic among the troops who brought the disease home with them. Cumberland county suffered greatly, and one observer wrote: "The fatal and not to be forgotten year 1759 when the Lord sent his destroying angel to pass through this place and remove many of our friends into eternity in a short space of time." Fortunately, inoculation, which had languished as a result of unfavorable results, experienced a revival due to improved methods of preparing the patient. Bodo Otto, recently arrived from Germany and settled in the Cohansey district of West Jersey, was familiar with smallpox inoculation and helped to control the epidemic in that region.

The most famous inoculator in the province was William Barnet of Elizabethtown whose improved technique of preparing the patient was said to have saved thousands. Benjamin Rush recalls that Barnet was invited to Philadelphia in 1759 to demonstrate his method and five years later he was called to Boston to open the first inoculation hospital in the country at Shirley Point.

Cochran, missing the stimulus of association with fellow surgeons, became a leading spirit in the founding of the Medical Society of New Jersey which held its organization meeting at New Brunswick on July 23, 1766.

The first important transaction of the Society was the establishment of a uniform fee schedule, but this met with apprehension on the part of the public and was subsequently modified. Of more lasting influence was the passage by the legislature (1772) of "An Act To Regulate the Practice of Physic and Surgery within the Colony of New Jersey." Designed to eliminate the quacks who flourished like the locusts in Egypt," this pioneer effort soon set the pattern adopted by Massachusetts and other colonies.

In the same decade, the first American medical schools opened in nearby Philadelphia (1765) and New York (1767), thus providing greater access to formal medical education for New Jersey men. Jonathan Elmer of Bridgeton and John Lawrence of Monmouth county were among the members of the first graduating class of the Philadelphia school, whose professors included such outstanding teachers as John Morgan, William Shippen, and Benjamin Rush—all European trained men who exerted wide influence on their Jersey students. Of the 70 prominent physicians mentioned by Wickes who practiced in New Jersey during the latter half of the century, 44 were college graduates, 27 from Princeton but only 6 of these held medical degrees from foreign medical schools.

A desirable influx of well-trained physicians of French Protestant extraction came to New Jersey during the period under discussion. Exiled from their homeland by the Edict of Nantes, these descendants of Huguenots included Daniel DeBenneville of Moorestown, Nicholas Belleville of Trenton, John Broguard of Burlington, Peter LeComte of Freehold,

and John A. de Normandie of Burlington. Born in the latter town and closely related to the de Normandies was John Bard, who with his son Samuel, was to become influential in New York medical affairs. Bard performed the first dissection in this country for teaching purposes (1750) and his son helped to found the medical school of Kings College (1767) and New York Hospital (1771). During the Revolution, the loyalist Samuel returned briefly to Burlington where he worked in a vain effort to manufacture salt from sea water.

THE MILITARY AND MEDICINE

The decade following the foundation of the Medical Society of New Jersey was one of great political agitation as the public (and families) split on the subject of separation from the mother country. There was no political unanimity among the physicians and several of the more prominent and wealthy men decided to remain loyal to the Crown: Absolom Bainbridge of Princeton, David Bancroft of Burlington, John Boggs of Shrewsbury, William Bryant of Trenton, the Reverend Isaac Brown and his son Samuel of Newark, William Chandler of Elizabethtown, Aaron Forman of Hunterdon County, John Hammell and Charles A. Howard of New Brunswick, Uzal Johnson of Newark, John Laurence of Perth Amboy, John A. de Normandie of Trenton, and the Reverend Jonathan Odell of Burlington. On the other hand, over 70 Jersey physicians who were of an age to fight, left their practices to receive commissions either in the state militia or in the Continental Army. Early in the Revolutionary War (1775) smallpox became epidemic among the troops and civilians of the Boston area, and Washington, who at first feared inoculation as a general measure, finally was persuaded by Director John Morgan to adopt the measure enthusiastically.

On July 15, 1776, the famed Philadelphia anatomist, William Shippen, Jr., who previously had refused the position of Director-General of the Medical Service, offered to him by General Washington, was appointed Chief Physician to the Jersey Flying (Field) Hospital at Amboy, under the leadership of General Hugh Mercer, himself a well-trained physician. Shortages of supplies becoming immediately apparent, Shippen had the following advertisement inserted in a Philadelphia paper: "The good people of this city and province and of the province of New Jersey are earnestly desired to send all the old sheets and other old linen they can possibly spare to Dr. Shippen, Jr., for the New Jersey Hospital. None will refuse complying with this request when they consider that the lint and bandages made of the linen may be used in dressing and caring for the wounds of their own fathers, husbands, or sons."

Shippen's originally optimistic tone faded by the fall of 1776 as a "putrid fever" began to attack men of the Flying Camp. Furthermore, the growing struggle for authority and the lack of cooperation between Shippen who had been granted full authority in New Jersey and Morgan who was confined to the west bank of the Hudson undoubtedly greatly increased the suffering of the sick in our state during this trying period.

New Jersey first felt the full impact of the war in mid-September 1776, when the Continental troops defeated by the British at the battle of Long Island were forced to evacuate New York City. Washington ordered John Morgan, Surgeon-General, to transport abou 1,000 sick and wounded over to the Jersey side of th Hudson, a heroic task which, despite "dreadful co fusion and disorder" Morgan accomplished with th aid of William Burnet, the leading surgeon of Newar The latter, overriding the fears of infection of the loc inhabitants, helped Morgan establish a general hosp tal, using the two local churches, the court house, ar the Academy; in October a second 300-bed facility wa established at Hackensack.

As the battered troops of the American Army fl south towards Trenton, other sick and wounded we placed in Amboy, Elizabeth, and New Brunswick. In th latter town, Washington was joined by John Cochra the zealous Whig, whose house became the target f British wrath. Cochran soon became a member Washington's official "family" and later, in Janua 1781, succeeded Shippen as Director-General of th Hospital. In late December, Trenton saw the tid change, but the death of General Mercer a few weel later, from an infected bayonet wound received at th battle of Princeton, cast a pall on the troops and med cal corps alike.

On January 9, 1777, John Morgan was summari dismissed from the Army, to be superseded by h arch-rival William Shippen, Jr., in April as Surgeo General. At this time many of the sick and wounde in Jersey hospitals were transported to Pennsylvani however, New Jersey was to remain the "cockpit of th Revolution," with one-third of all the fighting takin place on her soil.

At Morristown, where the army spent the winter 1777, the small community was infected wit smallpox, introduced by the troops. Inoculation b came the order of the day, and John Cochran supe vised the procedure at the Jockey Hollow Huts with very low mortality rate of about 3 in 400 patient Civilians were treated by Reverend Green in the tw churches of the town, while a smallpox hospital wa established at Hanover for soldiers who had contracte the disease in the "natural way." Another was estab lished at Trenton Barracks which remained under th supervision of the experienced Bodo Otto, who wa joined by his son, John Augustus, from July Christmas of 1777, when the two men left for Valle Forge.

The problem of an adequate nursing staff was plague the Continental Army for the duration of th war. On June 17, 1777, General Washington at Middl brook ordered that a "proportionate number of wome to the sick of each regiment shall be sent to the hosp tals at Mendham and Black River to attend to the sic as nurses." In November and December 1777, after th defeats at Brandywine and Germantown, and the los of Philadelphia, 400 sick and wounded were crowde into the small town of Princeton where the hospit was established at Nassau Hall, a structure whic could accommodate at best only 150 men. A devasta ing putrid infection (typhus) soon developed whic carried off scores of injured who had come to the hos pital solely for treatment of wounds. Death came to n less than six surgeons at this charnel house an James Tilton, who barely escaped with his life, has le us a vivid description of the morbid scene. Fortunatel other Jersey hospitals at Bordentown, Trenton, an

rlington seem to have escaped this infection.

On June 28, 1778, the Americans, marching from lley Forge, tried unsuccessfully to stop the British o were retreating from Philadelphia to New York. At e battle of Monmouth, many were prostrated by the tense heat, the sick and wounded being cared for in e Freehold Courthouse and several local churches. hers were moved to the New Brunswick barracks d to Morristown where the hospital was reopened. ter in 1778, the bulk of Washington's army enmped for the winter at Middlebrook, from which the v sick and wounded were sent to hospitals at Bound ook and New Brunswick. This winter proved to be usually mild and healthful, and it was at Middlebook that Washington ordered a series of lectures to supervised by Dr. William Brown of Virginia, Physian-General of the Middle Department—this may ll have been the first such course ever to be given New Jersey.

The following winter (1779 to 1780) the Army again ose Morristown, but during this winter the climatic nditions proved to be appalling, exceeding in severity e harsh period at Valley Forge. The men were forced sleep in tents until February when huts finally could erected. Despite the frightful weather, mortality was w; the number of fatalities at the small general hospils at Basking Ridge and Pluckemin from December 79 to June 1780 amounting to only 86 of a force of ,500 men. It was at Basking Ridge that surgeon mes Tilton had the opportunity to construct a novel edical hut. Windowless, with an earthen floor, and a ntral fireplace whose smoke circulated throughout e hut before leaving through an aperture in the roof, e construction was credited with cutting down on fections and mortality. The huts at Jockey Hollow, hich had been used by the Pennsylvania line until ly 1780, then were reopened as a general hospital. ck men were sent there from the Paramus encampent, and the huts were still in use as late as June 81.

HE POSTREVOLUTIONARY YEARS

With the war almost over, the Medical Society of New rsey immediately resumed its activities in November 81, and by 1790 was incorporated formally by the gislature for a period of 25 years.

Topics which engrossed the minds of the better ained physicians of the day can be found in the nual addresses given by the presidents of MSNJ om 1767 to 1795: use of lancet in pleurisy (emema); intermittent fevers; putrefaction; inoculation; operties of blood; nephritis; cachexia; changes of ood in disease; mechanisms of the human dy—fluids and solids; health and disease; nutrition; ature and uses of animal secretions; natural henomenon of sleep; chemical principles of bodies; fferent properties of air contained in the atmosphere; tridity; cyanche; causes of vital heat and animal nctions; beneficial effects of bathing; dropsy; and lmonary consumption.

At this period Paul Micheau, a well-trained physician, fostered a schismatic group known as the Eastn District Medical Society, in opposition to the Medil Society. Apparently with the idea of founding a edical school, Micheau also gave a course of lectures on the practice of medicine, from May 10 to July 25, 1790, for which he charged the sum of five pounds. Drawing on the heavy concentration of physicians in the Newark-Elizabethtown area, he made it impossible for the parent society to assemble a quorum in West Jersey where only one-sixth of the Society's physicians resided. As a result, the State Society remained quiescent from 1795 until 1807 when meetings were resumed. By 1800, ten New Jersey physicians had been granted the medical degree by schools in Philadelphia and New York. During this very period Jenner's vaccination was introduced into Boston by Benjamin Waterhouse. It was Lewis Condict of Morristown, a friend of the latter, who first brought the method to New Jersey in 1802. It was adopted by Cyrus Pierson of Essex County and James H. Stokes of Moorestown, with all three men testing the effect of vaccination on their own offspring by later exposing them successfully to smallpox. John Bowne of Ringoes, who at one time had 300 young persons under inoculation, also put vaccination to the severest tests in order to prove its efficacy.

Following the resumption of Society meetings in 1807, topics discussed included inflammatory peripneumonia, puerperal fever, tetanus, pneumonia typhoides, psoas abscess, fungus hematoides, intussusception, digitalis, calomel, alkalies in pulmonary consumption, and chorea.

Women, who had been taught the rudiments of medical care, continued to dominate the practice of obstetrics; one early example being "Aunt" Peggy Warner of Warren County who defied rain and snow during the Revolution in her travel on horseback along unlit country roads. The man-midwife finally made his way to New Jersey, and by 1775, a retired army surgeon in Rahway was advertising that he was skilled in the art of midwifery after studying at the famous Lying-In Hospital. James Stratton of Swedesboro also was familiar with the use of Smellie's forceps. The charge for natural delivery was 1 pound 10 shillings; preternatural, using forceps, 3 pounds. Other women assisted their fathers and husbands; one example being the wife of Dr. Garret Banta of Bergen County, who acted in a position very similar to our paramedics, and Elizabeth Haddon, after whose family the town takes its name, was noted for her skill in preparing botanical remedies.

In 1786, the Legislature renewed the licensing act of 1772, eliminating the requirement that two superior court judges be present at the examination.

In 1792, Queens College (Rutgers) entered into an agreement with Dr. Nicholas Romayne and three other physicians of New York City whereby students who graduated from his medical school were given the medical degree which the College was authorized to grant. By 1816, at least 34 degrees had been granted. This agreement, although sanctioned by the Medical Society of New Jersey (1827) eventually was terminated by action of the New York State Legislature.

It was during this period that Princeton considered opening a medical school. In 1795, the famous English physician-chemist, John MacLean, who was practicing in Princeton with Ebenezer Stockton, had been invited to give a course in chemistry at Nassau Hall. So successful was this venture that for a while the Trustees

thought of expanding the project; MacLean remained an officer of the college from 1797 to 1812, yet his efforts made no progress.

In 1816, the Society was reincorporated by the State and the Board of Censors of the various constituent societies was instructed to hold three-hour examinations for admission on such subjects as anatomy, materia medica, pharmacy, chemistry, physiology, surgery, theory and practice of physic, and midwifery. Examinations were to be open to the public and the successful candidate was "granted the privilege of practicing physic and surgery in this state." However, it was not until 1825 that the state legislature finally conceded to the Society the right to grant medical degrees, thus placing the Society on a par with Princeton and Rutgers. It was at this period that Princeton made a second effort to found a medical school, when John van Cleve, the brilliant practitioner of the town, gave a series of lectures on medicine. Unfortunately, his death in 1826 again terminated the project.

Some of the most popular remedies of the period included nitre, Jesuit's bark (quinine), numerous evacuants including jalop, rhubarb, senna, and aloes; mercury and antimony, tartar emetic, and cartharides. At least one New Jersey physician resisted the tendency to large dosage. Lawrence Vanderveer of Somerset county insisted on prescribing small doses, thus anticipating Samuel Hahnemann's homeopathy in this regard. As for charges, phlebotomy cost 1 shilling; tooth extraction 1 shilling 6 pence; inoculation 7 shilling 7 pence. Charges for medication usually rendered the bill much higher. In one case, for severe headaches (impending stroke), Moses Elmer directed the letting of blood, to be repeated every few days as the patient's strength permitted. In addition, a seton was to be applied to the neck to promote the discharge of pus, and, of course, calomel to be continued. Contrasting views on the proper treatment of fevers split the fraternity. Thus, the same Moses Elmer refused to give a patient a drop of water until the desperate man managed to get to a pail of water, drank all he could and having finally recovered, informed the doctor what had cured him; on the other hand, Franklin Hoven in an epidemic of typhus fever, following the more rational teachings of Sydenham, gave his patient cooling drinks ad libitum and earned for himself a great reputation.

New Jersey produced a singular character in the herbalist Peter Smith (1753 to 1816). Although the son of a physician, and a graduate of Princeton, he elected to spend his life wandering with his family through the southern and midwestern states accumulating information on the virtues of plants from anyone he met. His "Indian Doctors' Dispensatory" is a mine of information about native medicinals.

Finally, in the interest of the public the Society had appointed in 1810 a Standing Committee to study weather conditions throughout the state, correlating these with current diseases. Organized with John van Cleve of Princeton as Chairman, the Committee 1820 expanded to include bills of mortality concerni births and causes of death.

CONCLUSION

In closing this brief resumé of the principal ever in our early medical history, I wish to point out son of the political and other avocational activities whi engrossed the attention of the outstanding physicia of this period: Oliver Barnet—judge of Common Ple John Beatty—trustee of Princeton and member of Co gress; Moses Bloomfield—abolitionist who freed slaves on July 4, 1783; William Burnet—member Continental Congress and judge of Common Ple Jabez Campfield—founder of Morris Academy and tive in Warren County Agricultural Society; John Co dit—member of Congress and founder of Oran Academy; Lewis Condict—member of Congress a trustee of Princeton; Samuel Dick—member of Co tinental Congress and surrogate; Jonathan Elmer member U.S. Senate, judge of Common Pleas; Ebenez Elmer—member of Congress, judge Common Ple Jacob Green—founding trustee and vice-president Princeton; Thomas Henderson—member of Congre and judge of Common Pleas; Moses Jaques—abo tionist; Lewis Johnstone—botanist; Samuel Ke nedy—headmaster, Basking Ridge School; Jo MacLean—professor of chemistry and natural histo and mathematics at Princeton; William McIlvane trustee of Burlington Academy; John A. de No mandie—active in Burlington County Society f Promoting Agriculture; Jonathan Odell—member American Phil. Society; Robert C. Patterson—preside of American Phil. Society and professor of mathema ics at University of Pennsylvania; Isaac Pierson—mer ber of Congress; Cyrus Pierson—founder of Caldw Library; George Ross—trustee, Elizabeth Academ Moses Scott—member of Congress; Charles Smith trustee of Queens College; Nathaniel Scudder- member of Continental Congress and trustee Princeton; John Anderson Scudder—member of Co gress; Isaac Smith—member of Congress; James Stra ton—judge of court; Samuel Swan—member of Co gress; Hedge Thompson—member of Congress a county judge; Lawrence Vanderveer—trustee, Queer College; John van Cleve—trustee, Princeton; Abraha VanBuren—trustee, Queens College; and Thomas Wi gins—treasurer, Princeton.

REFERENCES

1. Cowen DL: *Medicine and Health in New Jersey: A Hi tory.* Princeton, NJ, Van Nostrand Co., 1964.
2. Duffy J: *Epidemics in Colonial America.* Baton Roug LA, Louisiana State University Press, 1953.
3. Wickes S: *History of Medicine in New Jersey, and i Medical Men from the Settlement of the Province to 180* Newark, NJ, Martin R. Denis & Co., 1879.
4. Rogers FB, Sayre AR: *The Healing Art.* Trenton, N Medical Society of New Jersey, 1966.

BROWN **THE BROWN PHARMACEUTICAL CO., INC.**

2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

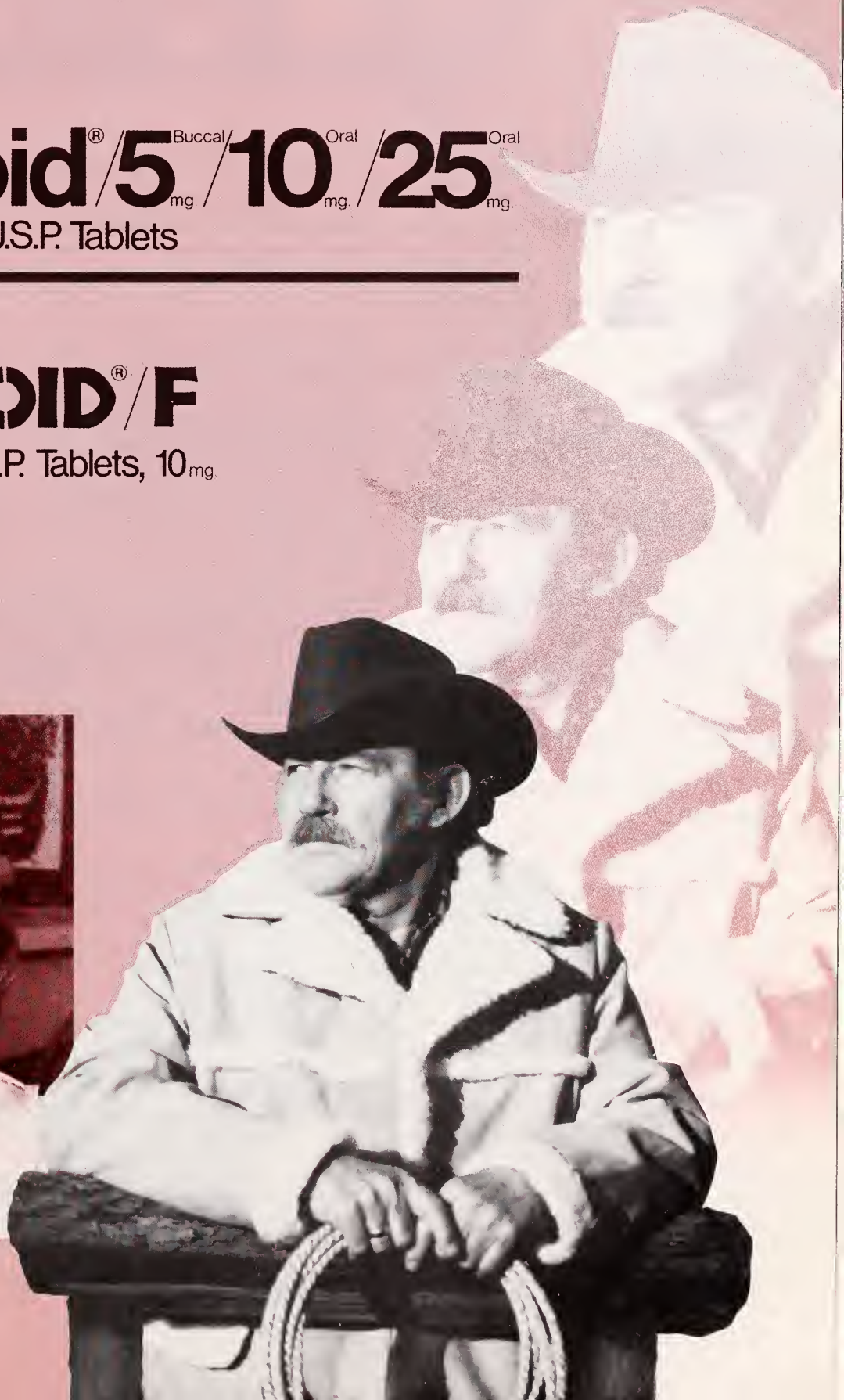
Android®/5 mg. Buccal/10 mg. Oral/25 mg. Oral

Methyltestosterone U.S.P. Tablets

ANDROID®/F

Fluoxymesterone U.S.P. Tablets, 10 mg.





Thinking con

Think

As in Blue Cross of New Jersey. *The* single source for computerization.
☐ Because Medical Management Services from Blue Cross now offers a unique automated office system.
☐ Only Blue Cross offers this unique system, because only Blue Cross has the experience in the health care field (half a century's worth!), the data processing know-how and the claims processing expertise to make it all work efficiently and effectively.

The system itself.

You receive a stand-alone system using IBM or Texas Instruments computers that is physically located in your office. It is operated by your office personnel—they do not have to have any data processing experience—and the system is completely under their control at all times.

The software and system support.

This modular system provides a complete software package for your office which utilizes Blue Cross' expertise in health care financing, automated hospital admission/approval systems, automated claims submission, and leadership in paperless processing. Only Blue Cross can offer the benefits of this wealth of experience and offer single source capability for computerization.

Your people receive full and complete training and ongoing support in system operation. We accept full responsibility for hardware and software maintenance.

What the system does for the physician.

Whether you are an individual or group practice, this system will relieve paperwork...provide fast access to necessary patient information...and give you much more time to tend to the clinical aspects of your practice.. and, above all, increase the efficienc of the office and the income of the practice! All from a single source for computerization.

Some of what you get with the System:

- An easy-to-use system.
- Instant access to patient account information by account number.

Take a minute to check this list!

- ☐ Your volume is at least 80 patients per week.
- ☐ Your daily cash control and records keeping procedures need to be improved.
- ☐ Your receivables are greater than 17% of your total annual charges.
- ☐ You are forced to write off more than 5% of your net receivables as uncollectable.
- ☐ You are running behind in your insurance billings and collections.
- ☐ Your service bureau already charges you more than $4,200 per year.
- ☐ You experience a high turnover of clerical employees or need to increase the productivity of your present staff.
- ☐ You find it difficult to get complete and current data on patient treatment patterns, facilities utilization, and services on a regular weekly, monthly and annual basis.
- ☐ Your quarterly and annual payroll reports are now done manually.
- ☐ You have difficulty getting useful management information about your practice when you need it.
- ☐ Your "most current" financial statement for the practice is already out of date.

If you have checked off any of the above, you are a candidate for Medical Management Services.

puterization?

blue.✓

Production of patients' statements on daily, weekly or monthly basis —whichever billing cycle is best for your practice.

Automatic production of standard insurance (AMA) claim forms.

A daily charge and collection summary which recaps all daily patient activity.

An aged accounts receivable trial balance which can be printed on demand.

Practice productivity reports broken down by procedures and payment classifications (insurance, self-pay, etc.)

- Monthly management reports.
- Medicare payment distribution (20% of co-pay automatically calculated if assignment is accepted).
- Single-date entry for all financial transactions.
- A recall system which prints lists, statistics and "labels."
- Customized reports for special requirements.
- Automatic retention of claims information for rebilling purposes.
- Improvement in cash flow and office efficiency.

Free Office Analysis

Included in the services provided is a free office analysis where a Medical Management Services representative analyzes pertinent data on your current work flow, patient volume, initial set-up for new patients, billing, insurance filing and follow-up. This Office Analysis is a prerequisite for installation and is made at no charge.

Fill out the coupon, or call, for further details and to initiate your Office Analysis.



Medical Management Services

P.O. Box 8
Florham Park, NJ 07932
(201) 966-2710

Blue Cross of New Jersey ®

Medical Management Services
Blue Cross of New Jersey, P.O. Box 8, Florham Park, NJ 07932

☐ Please send me additional information.
☐ Please have a representative call to arrange an Office Analysis.

Dr. _____

Office Address _____

City _____

State/Zip _____ Office telephone _____

® Registered Marks Blue Cross and Blue Shield Association

MSNJ: America's First and Oldest Medical Society

Geraldine Hutner, Lawrenceville*

On July 23, 1766, a group of physicians met at Duff's Tavern in New Brunswick to initiate the first medical society in the United States. This group elected officers, set a table of rates and fees, and signed a 14-item constitution to improve the health and welfare of citizens in the state of New Jersey.

In the 1700s, New Jersey distinctly was divided into two regions: East Jersey, the Dutch and English settlement in the North; and West Jersey, the southern province from Cape May to Burlington. When the Duke of York gained control of New Jersey State, he united both sections—forming New Jersey.

Approximately 150,000 people lived in New Jersey, with 29 percent of the population in the south. There were 88 physicians in the state in 1766—1 physician for every 1,500 persons in the north and 1 physician for every 2,400 persons in the south (Figure 1).[1]

At this time, midway between the French and Indian War (1758) and the War of Independence, "the battle against disease was a one-sided affair in which illness normally triumphed over the doctor's primitive weapons of bleeding, cupping, and purging."[2] Physicians in New Jersey felt they had to help their profession, to set standards, fair practices, and exchange medical information. In the book of minutes (Figure 2) from the first medical society meeting in New Jersey, mention was made: "of the low state of medicine in New Jersey, and the many difficulties and discouragements, alike injurious to the people and the physician ... having for several years engrossed the attention of physicians."[3]

On June 27, 1766, a notice appeared in the *New York Mercury* newspaper stating:

> A large body of the practitioners in physic and surgery in East New Jersey, having agreed to form a society for the advancement of their profession and the promotion of public good, hereby request and invite every gentleman of the profession in the province to attend a meeting at Mr. Duff's Tavern in the city of New Brunswick on Wednesday July 23, at which time and place, the Constitution and Regulations of the society are to be settled and subscribed.[3]

On the corner of Albany and Peace Streets, New Brunswick, at Duff's Tavern, 17 professional men met for this voluntary, organizational meeting. At this time New Brunswick was a center of travel, on direct route from New York to Philadelphia; hence, the perfect meeting place.

As noted in *The Healing Art*, "The men were a prepossessing sight. The few who lived near and were inclined to formal dress wore white Geneva bands at the collar; others appeared in good black broadcloth with white cravat, ruffled shirt, silk hat, and even a wig.... More were dressed as befitted those constantly in the saddle: dun-colored kerseys, blue broadcloth coat, linen homespun shirt, wool or yarn stockings, felt hat, plain silver buckle at shoe and knee, and shoulder

*Ms. Hutner is Managing Editor, *The Journal*, MSNJ.

ew Jersey in 1766, showing:
The boundaries of its 13 counties.
Their population—census of 1784.
The number of their known physicians.
Founder of the Medical Society of New Jersey.
Joined later.
Nonmembers.

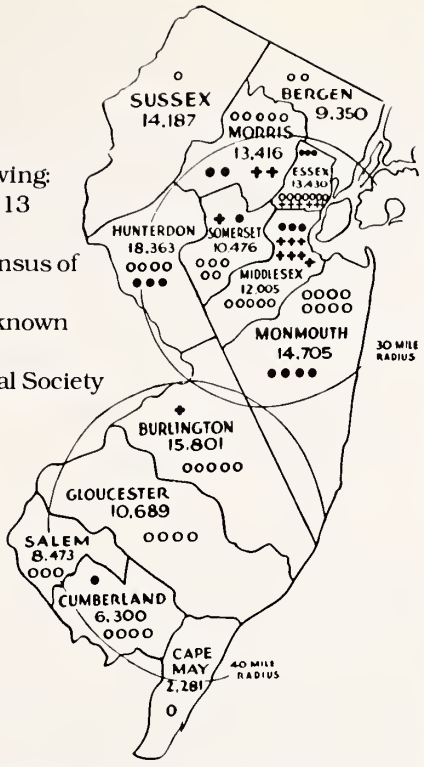


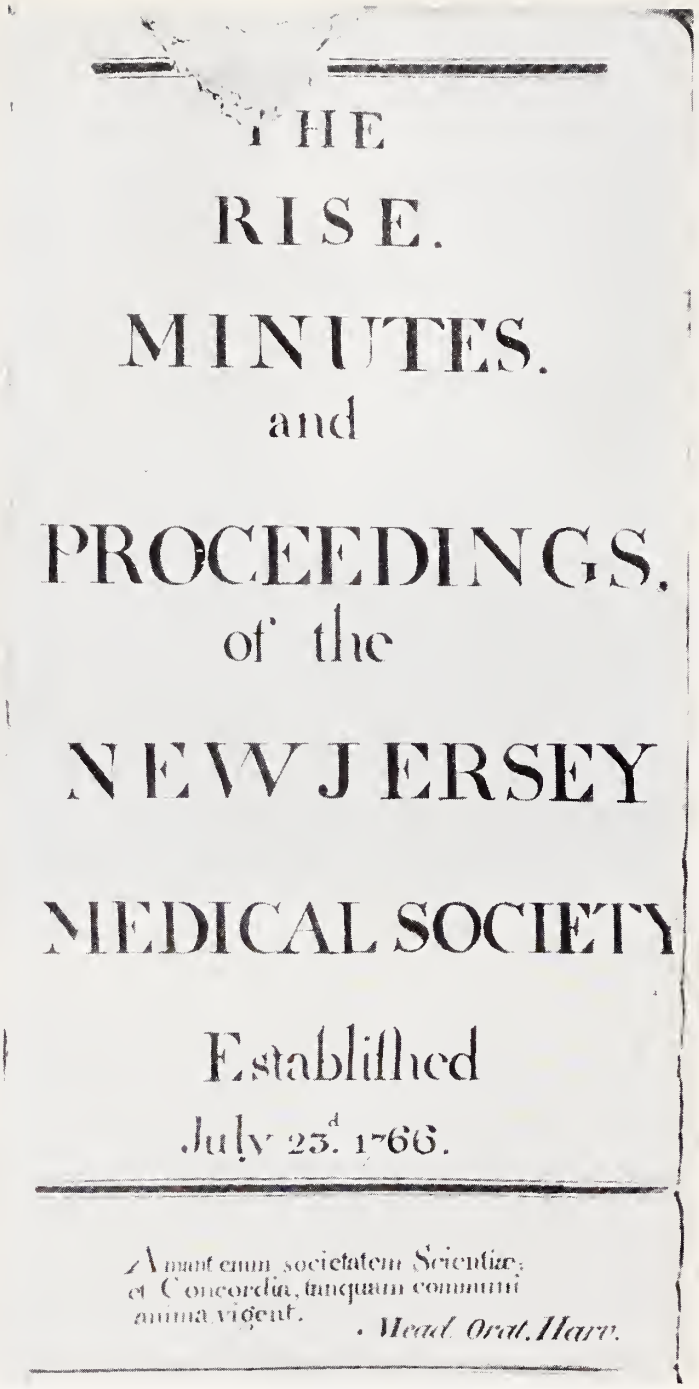
Figure 1—A look at the state of New Jersey in 1766, showing population and physician figures.

length hair loose or gathered at the nape with a deer thong. One or two wore military uniforms."[4]

The first order of business at this meeting was the election of officers. Reverend Dr. McKean, at age 34, was voted president. Dr. McKean, a man of considerable fame and respect, studied medicine and theology abroad. He was a minister and teacher at St. Peter's Anglican Church, in addition to his duties as a physician. Dr. Christopher Manlove was elected secretary and Dr. John Cochran was elected as treasurer, for one year.

As secretary, Dr. Manlove kept the minutes. The long, narrow, yellow cardboard book still exists and is at the library of the New Jersey Historical Society. Fourteen signatures were affixed to this book entitled, "Instruments of Association and Constitutions of The New Jersey Medical Society:" Drs. Robert McKean, Christopher Manlove, John Cochran, Moses Bloomfield, James Gilliland, William Burnet, Jonathan Dayton, Thomas Wiggins, William Adams, Bernet Budd, Lawrence V. Derveer, John Griffith, Issac Harris, and Joseph Sackett, Jr.[3] Three more physicians arrived at Duff's Tavern in the afternoon: Drs. Stephen Campe, Ebenezer Blatchly, and an unidentified third man (Figure 3).

The newly signed Constitution of this association listed 14 items to be upheld by the membership. In the introduction of this document the signers noted, "Medicine is one of the most useful sciences to mankind." They believed if they were united in a well-regulated society they would improve the health and welfare of every town, neighborhood, and district through encouraging honesty, integrity, and frankness in all matters relating to doctors and patients.[3] The 14 obligations cover a wide spectrum, but all kept in line with the Hippocratic oath and the proper practice of medicine. The Constitution laid out the purposes of the Society and specific functions, with meetings twice each year and an annual election of officers. The members also agreed to serve the poor, to discourage quackery, to seek consultations when needed, to improve licensing requirements, and to disseminate medical knowledge.


THE
RISE.
MINUTES.
and
PROCEEDINGS,
of the
NEW JERSEY
MEDICAL SOCIETY
Established
July 23d. 1766.

Amant eum societatem Scientiæ et Concordia, tanquam communi anima vigent. Mead. Orat. Harv.

Figure 2—The cover of the book of minutes from the first Medical Society meeting.

The membership then dealt with the question of a table of fair fees and rates. As the minutes of the meeting noted, "That there was no law or custom throughout the province for the paying of regulation fees, for advice, and attendance," and it was decided that "one general and uniform mode of charging" should be instituted.[4]

It must be remembered that the committee of men (Drs. Cochran, Wiggins, Blatchly, and Sackett) who drew up the list of fees had great difficulty; they all came from different parts of the state and had varying financial concerns. After much discussion they did agree on a fixed schedule after noting in the preamble to this 'rate card' the following:

> The New Jersey Medical Society considering the state of medical practice in this Government, and

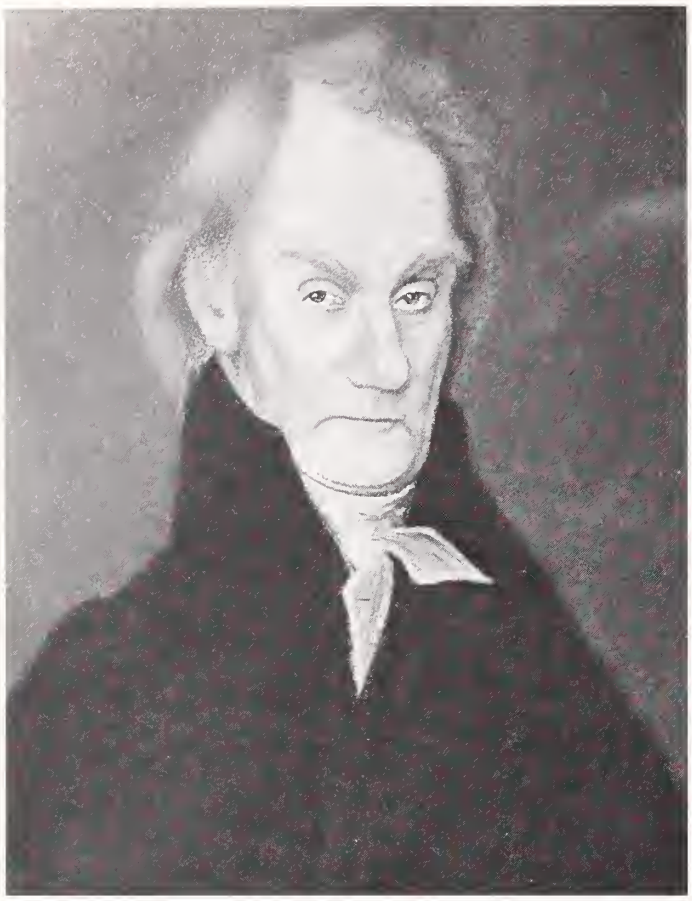


Figure 3—Dr. Lawrence V. Derveer, one of the original signers of the Medical Society Constitution, in 1766.

apprehending that as they have separated themselves to a profession that not only deprives them of many comforts and indulgences ... by being at the call of anyone, day or night; but also exposes them to many disagreeable scenes and often to great dangers from contagious diseases, etc.; besides the great expense of education and the many painful years to be employed in preparatory studies, as well as that of the science itself, they are in an especial manner entitled to a just and equitable reward for their services, at least to live by this their useful profession.[4]

A sampling of the rates (Figure 4) gives a look at the most common complaints of that time.

The second meeting of the New Jersey Medical Society was held on November 4, 1766, in Elizabethtown. The most important item on the agenda was the problem with the proposed fair fees and rates schedule. The New Jersey public felt a specific cost for medical care, determined in advance, was outrageous and that physicians were trying to take advantage of the population. Backed into a corner, the Society members abolished the prescribed rates and fees schedule. They decided each physician could set his own schedule of rates, as long as he did not exceed the proposed table of rates.

The membership was not interested solely in economic matters at this meeting; they showed concern for medical and scientific information. The Society felt the physicians should exchange information, opinions, cases, and other relevant material at all meetings. Hence, the first paper was read: Dr. Burnet discussed the use of lancet in pleurisy. The membership then

SAMPLING OF RATES

Call	Cost £	s	d
An ordinary call, up to a mile and a half	0	1	6
Each additional mile	0	1	0
Simple fracture of the thigh or leg bone with necessary dressing during the cure	2	0	0
First dressing a wound, including unguents	0	7	6
Amputation of a leg or thigh	3	0	0
Extirpation of the tonsils	1	0	0
Extracting a tooth	0	1	6
Obstetrical care	1	10	0

Figure 4—A sampling of the rates.

voted that each member would be required to read paper or present a case for discussion at every meeting In fact, history has noted that "learned discussion wa the 18th century's device to overcome the scientifi shortcomings of the age of medicine."[5]

The third meeting of this association was held o May 5, 1767, in Amboy, and the main topic of dis cussion was the education of future physicians. In thi day and age, medical practice was taught by observa tion—the preceptor-apprentice method. The *Trans actions* from this meeting noted:

Some members motioned that the method of educating young gentleman for the study of physic had not been properly adverted to in this Government, but very much neglected, greatly to the detriment of the profession. The Society took the same into consideration, and agreed that for the advantage of youth and honor of the art, that no student be hereafter taken an apprentice by any member, unless he has a competent knowledge of the Latin and some initiation in the Greek. The time for apprentices serving never being yet settled, though an affair of considerable importance, was taken into consideration. The sentiments of the members were very different, but finally agreed that no member do hereafter take an apprentice for less than four years of which three shall be spent with his master, and the other way (with his master's consent) be spent in some school of physic in Europe or America. It appearing absolutely necessary to fix apprentices fees, the sum of 100 pounds, proclamation money, was agreed upon being very low, and no more than a bare acknowledgement for board during the above term.[6]

The apprentice method was advantageous to all in helping the physician and teaching the student. One must remember that at this time, one of the first medical schools in the country, the University of Pennsylvania, was just beginning.[7]

After this meeting the New Jersey Medical Society grew rapidly, becoming an influential and educational association for the state of New Jersey and the United States. The value is inscribed on the seal of the Society, "I am known throughout the world as one bearing aid."

EFERENCES

1. Davidson HA: The Medical Society of New Jersey. *Mass ıysician* 28:46-48, 1969.
2. Medical World News: New Jersey marks bicentennial. ıgust 26, 1966.
3. The New Jersey Medical Society: *The Rise, Minutes, and ɔceedings of The New Jersey Medical Society.* Newark, NJ, ɛnings & Hardham, 1875.
4. Rogers FB, Sayre AR: *The Healing Art.* Trenton, NJ, Medical Society of New Jersey, 1966.
5. Cowen DL: *Medicine and Health in New Jersey: A History.* Princeton, NJ, D. Van Nostrand Company, 1964.
6. New Jersey Medical Society: *Transactions,* May 5, 1767, p. 18-19.
7. Marsh EJ: An outline history of the Medical Society of New Jersey to 1903. *Proc NJ Historical Society,* January 1942.

The RCA solution for paperwork headaches.

Introducing the cure to all your administrative headaches. The Medical Management System from RCA. This unique system was designed by a physician for physicians. It handles everything from insurance claims and patient billing to invoice tracking and cash disbursements. It takes the hassle out of time-consuming billing procedures and gives you greater control of the business side of your practice.

You'll feel good about the RCA Medical Management System when you see the price, too. It's affordable. Easy to use. And includes an IBM personal computer, a high-capacity disc storage unit, a printer, and the RCA Medical Management software.

We'll take care of everything — delivery, installation and user training. And the entire system is backed by RCA's one-year, on-site service warranty.

Make an appointment today to see a special demonstration of the RCA Medical Management System. Just call collect **(609) 338-4129** and let RCA help make your practice perfect.

RCA Data Services



The History of Medical Journalism in New Jersey

Arthur Krosnick, M.D., Lawrenceville*

The history of medical journalism in New Jersey is rich and illustrious. Linked by the practitioner's eagerness to transfer information to others, journals and periodicals have become a storehouse of interesting and stimulating material.

Although journalism is the business of managing, editing, or writing for journals or newspapers, the distillation of this concept is the communication of ideas. From Hippocrates to the present, physicians and teachers have been obliged to share their knowledge and experience with students and peers. The transition from word-of-mouth and show-and-tell to electronic communication has been less a change in concept than an advance in technology. Emphasis has moved from description and empiricism to pathogenesis, laboratory and clinical testing, classification, and specific therapy over the past two-and-a-half centuries in New Jersey, but practitioners of medicine—from the barely trained novices and apprentices of the first half of the 18th century in New Jersey to the present scholarly scientists who manipulate DNA—are linked by their eagerness to transfer information to others.

LETTERS, ORAL COMMUNICATION, JOURNALS, AND DIARIES: 1623 TO 1766

Because of the development of language and the use of symbols to communicate ideas, man has distinguished himself from lesser creatures and has made giant strides from the cave to the computer. The spoken word was the bridge from practitioner to apprentice, even as it is today. Present-day medical and scientific meetings are based on a foundation of lectures and workshops—albeit supported by slides—but these differ mainly as to the size of the audience.

Colonial practitioners, who were few in number, used their senses for observation, palpation, and olfaction and auscultation (before and after the invention of the stethoscope) to make diagnoses and used their experience and instincts to make therapeutic decisions since the primitive state of medicine and medical education offered few alternatives. During the colonial and pre-Medical Society periods the majority of "physicians" had not received any formal training. The "practice of the healing art was chiefly in the care of the clergy" who were intelligent and well educated: "Many of them were distinguished for their knowledge in medicine, and were authors of some of the earliest medical papers printed in America. In some instances the schoolmaster also was the physician and surgeon of the neighborhood. When the literature of the profession was confined to the few writers of those early days, it was easy for the student in literature and science to furnish himself with the theories of medicine and practice."[1]

In the more sparsely settled regions of the colonies, women cared for the sick; being untrained, they turned to "medicinal recipes" in their family record books, many examples of which are stored in the manuscript collections of the New Jersey Historical Society.

*Dr. Krosnick is Editor, *The Journal*, MSNJ.

During the colonial period, physicians kept journals and diaries in which they recorded the dates, services (house call, phlebotomy, extraction of tooth, and medicines), and fees. This fascinating material points out the limitation of treatments (bleeding, purging, dressing, and reduction of fractures) and the regular dependence on empirical medicinals with modest concepts of dietary manipulation.

During the slow transition from observation, empiricism, and trial-and-error to a "medical science" in colonial New Jersey, the "doctor's" major resource for information was the spoken word. One can imagine the discussions about the first epidemic in the province, which virtually annihilated the Swedes and English in Salem Creek, about the first recognition of malaria at the end of the 17th century, and the initial cases of smallpox in 1715 and yellow fever in 1743 in Burlington. Diphtheria and scarlet fever were New Jersey scourges in 1735 and 1736, although they were not recognized as such.

Medical information was published in newspapers and in other nonmedical publications. A newspaper at the time carried the following item: "In July 1751, was committed to the care of Dr. Peter Billings, an experienced physician and man-midwife, and formerly in the King's service, the most extraordinary and remarkable cure that was ever performed in the world upon one Mary Smith, single woman. She had been upwards of 18 years out of her senses (most of the time raving mad), eating her own excrements, and was completely cured by him in two months—contrary to the opinion of all who knew her."

Modest communications in the form of descriptive letters probably were the first example of formal medical writing in those days. An early record of such a letter, written in 1738 and 1739, and later published as a pamphlet in Boston, was the handiwork of Rev. Jonathan Dickinson.

This publication, "Observations on that Terrible Disease Vulgarly Called the Throat Distemper with Advices as to the Method of Cure," was published in 1740 and doubtlessly represents the first published case report from a New Jersey physician. Jonathan Dickinson, a clergyman, theologian, physician, author, and first president of the College of New Jersey (Princeton University), wrote his first medical publication when asked about his experiences in New Jersey with the throat distemper in 1738. At the behest of a publisher he agreed to describe his observations and treatment. His paper contained a remarkable epidemiological and clinical description of "that extraordinary disease, which has made such awful desolations in the country, commonly called the throat distemper." Ultimately the deadly infection was called diphtheria (1826). Dickinson wrote "in the most plain and familiar manner" in order to "communicate to you some of my experiences in this distemper" and "to contribute what I can towards the relief of the afflicted and miserable." What an auspicious beginning by a clinician-writer for New Jersey journalism![1]

TRANSACTIONS OF THE NEW JERSEY MEDICAL SOCIETY

America's first medical society was formed at Duff's Tavern in New Brunswick on Wednesday, July 23, 1766, and was called the New Jersey Medical Society. The Secretary took minutes at this and each subsequent meeting by hand, and these were carefully preserved. At its Annual Meeting, May 25, 1875, the Society voted to examine and publish the old records. Stephen Wickes edited the *Transactions* from 1766 to 1859, which then were printed in a single volume. The title page, *The Rise, Minutes, and Proceedings of the New Jersey Medical Society*, from the original document, is held in the manuscript collection of the New Jersey Historical Society.[3]



Figure 1—Dr. Stephen Wickes (1813-1889) edited the *Transactions* which then were printed in a single volume. Dr. Wickes also served as 90th president of the Medical Society of New Jersey.

The *Transactions* represented the proceedings of the Annual Meeting and were highlighted by the President's address; they represent a gold mine of interesting and important medical, social, public health, and governmental and legislative issues. The inaugural address of the president often contained clinical material, e.g. the first tumor conference. In the 1785 *Transactions*, a 17-year-old boy was presented to the assembly who discussed the removal of a tumor from the patient's forearm. In 1787, Dr. William Burnet, who was the second president of the Society, delivered the first scientific paper by a member of the organization, "On the Nature and Importance of the Healing Art," which later was published.

THE NEW JERSEY MEDICAL REPORTER

Unlike the *Transactions of the New Jersey Medical Society*, the *New Jersey Medical Reporter* was the first professional journal "devoted to the interests of medical science generally." It was published quarterly by a very business-like editor, Joseph Parrish, M.D., of Burlington, who charged $2 per annum, payable in advance, or $10 for six copies to be sent to one address. Parrish warned that "those who wish to be placed on our subscription list will please make their remittances without delay." Volume I, No. 1, was dated October 1847 and included proceedings of the New Jersey Medical Society, committee reports, a rather testy commentary against the system of medicine started by

amuel Hahnemann, called homeopathy, and proceedigs of the National Medical Convention held in New ork in 1846 and in Philadelphia in 1847 (New Jersey as not officially represented by action of the State ociety). There is an editorial explaining the reasons r publishing the *New Jersey Medical Reporter:* To rovide the proceedings of meetings of the Society, to eproduce papers presented to District Societies, to lay efore the subscribers a general summary of medical cience such as may be obtained from the various indred periodicals of this country and Europe, and publish editorials, biographical notices, and other ems depending on available space. Parrish also wrote n editorial on the new scientific breakthrough, "Aplication of the Vapour of Sulphuric Ether in Practical Medicine and Obstetrics." There also were articles on plints, a case report (placenta praevia), book reviews, nd so on.[4]

In 1850, Dr. Samuel W. Butler, a new graduate from he Medical Department of the University of Pennylvania, commenced practice in Burlington and was ppointed assistant editor of the *Reporter.* In 1854, arrish retired and Butler became the editor and roprietor of the *Reporter* which he changed to a nonthly publication. He was so successful as an editor hat "in 1858 he determined to remove from the somewhat provincial quiet of Burlington to Philadelphia, at hat time, and largely still the professional metropolis f the country."[5] He then made another daring change, ltering the journal to a national weekly publication 10¢ a copy, $3 per annum) and retitling it, *The Weekly Medical and Surgical Reporter.* According to a subsequent editor, D.G. Brinton, Butler continued to publish he *Reporter* during the Civil War, "when nearly every ther medical periodical in the country was obliged to uccumb."

HE JOURNAL OF THE MEDICAL SOCIETY OF EW JERSEY

H. Genet Taylor first suggested a monthly journal in is presidential address in 1889. In September 1904, olume 1, No. 1 of *The Journal* commenced publiation under the direction of the Committee on Publiation, as ordered by the Board of Trustees in July of hat year. Richard C. Newton, M.D., of Montclair, was ppointed the first editor.

Some of the reasons for becoming a monthly were:) to enlist the interest (and membership in the Soiety) of younger New Jersey physicians; 2) to provide better means of communication among the members; 3) to make the members better acquainted with ach other, to induce them to attend and participate n meetings, and to promote a higher grade of scienific work; 4) to collect and print excellent addresses nd papers; 5) to induce the hospitals and asylums in lew Jersey to prepare and publish better scientific and linical reports; and 6) to aid collateral organizations, .g. state and municipal health boards, the Sanitary ssociation, and the State Board of Medical Examiners.[6]

It appears that the reasons have been fulfilled and ontinue to be valid. During the last 80 years, there ave been seven editors of *The Journal:* Richard Cole Newton (1904 to 1906); David C. English (1906 to 1924); Henry O. Reik (1925 to 1933); Alfred E. Shipley (1934); Frank Overton (1935 to 1940); Henry A. Davidson (1941 to 1973); and Arthur Krosnick (1973 to present).

The Journal has remained the mouthpiece of the State Society, but its editors have functioned with independence and honesty. While the character of *The Journal* has changed very little, its style has varied with the times, reflecting advances in medicine and science, changes in socioeconomic and legislative circumstances, and the needs of the members of the Society.

Older issues are a storehouse of exciting medical facts that link practitioners through many aspects of health and science but especially at the moments of great discoveries or worldly events. Four wars have intervened during the life of *The Journal,* and the scientific discoveries have been so numerous as to defy tabulation in this essay. Names like Ehrlich and Mayo, items like paper milk bottles and the roentgen ray, and drugs like sulfa and recombinant DNA insulin, are in the pages of *The Journal.*

A number of significant changes have characterized our present award-winning magazine: 1) an active, participatory Committee on Publication; 2) appointment of a highly competent Editorial Board, manuscript reviewers, and book reviewers; 3) an up-beat, positive approach to covers, graphics, typography, readability, and editing; 4) a strong participation by university-affiliated authors and contributors to special departments; 5) emphasis on current and future trends in health, economics, professional liability, governmental and regulatory influences, and the role of the physician and organized medicine in New Jersey's health care system; 6) a staff with publication skills at the cutting-edge of the craft; and 7) special issues.

In 1947, MSNJ started a *Periodic Newsletter* during the presidency of Royal A. Schaaf of Newark with Richard I. Nevin, emeritus executive director and editor; this became the *Membership Newsletter* with a change from a special-subject publication to a more diverse, 4-page periodical published under the direction of the Council on Public Relations with Vincent A. Maressa, executive director, as the editor. In July 1983, the *Membership Newsletter* was terminated as an independent publication and was incorporated in *The Journal.*

PUBLICATIONS AND HEALTH-RELATED JOURNALS

State Board of Medical Examiners of New Jersey Annual Report. The First Annual Report of the State Board was published in 1891. The Board was appointed July 8, 1890, under "an act to regulate the practice of medicine and surgery," which was known as the Medical Law and was approved March 12, 1881. The first published report "To His Excellency Leon Abbett, Governor of New Jersey," was submitted by Wm. Perry Watson, M.D., Secretary. It concerned itself mainly with the imperfection of the law and the ease with which individuals with bogus credentials become legalized physicians in this state.[7]

The first state examination was given on October 10,

1890, to 11 candidates for licensure to practice medicine; 10 passed and were granted certificates. Each report thereafter contained the scores of the examinees and the institution at which their medical education was obtained. The Ninth Annual Report indicated that 121 candidates were examined for license to practice medicine and surgery and 97 passed.[7]

Bulletin of the Academy of Medicine of New Jersey. The Academy, founded in 1911, did not establish a journal until April 15, 1955. The first *Bulletin* had James E. Gardam as acting editor, and served to provide to the Fellows of the Academy the proceedings of a symposium on heparin which was given at the Academy of Medicine on December 16, 1954. The President was Asher Yaguda, M.D. Some very illustrious scientific speakers and writers were represented in the *Bulletin*, which dealt with such timely subjects as corticotropin (Philips S. Hench, Nobel Prize recipient addressed this symposium), alcoholism, highway safety, and fluoridation. The *Bulletin* ceased publication in December 1970.[9]

Public Health News: New Jersey State Department of Health. MSNJ President George T. Welch's prediction in 1893 that a cabinet-level Secretary of Health would be appointed early in the 20th century came true. In 1865, the Legislature appointed a State Sanitary Commission, and in 1873 created the State Board of Health. In 1903, New Jersey became the first state to license municipal health officers and sanitary inspectors. In 1915, legislation established the State Department of Health to replace the Board and following this, a monthly publication, *Public Health News* appeared. This periodical still exists and reports current public health data, advice, and statistics.

New Jersey Journal of Pharmacy. The New Jersey Pharmaceutical Association was the first such organization in the United States when it was founded in 1870. The origin of the Association was a conference with members of the Essex County Medical Society. The *New Jersey Journal of Pharmacy* succeeded the *Proceedings* of the Association in 1927 and is published monthly.[12,13]

The Country Practitioner* or *New Jersey Journal of Medical and Surgical Practice. Published 1879 to 1881 by Dr. E.P. Townsend at Beverly.[11]

New Jersey Eclectic Medical and Surgical Journal. Published in New Jersey from 1874 to 1876; then moved to New York.[11]

New Jersey State Homeopathic Medical Society. Published *Transactions* or *Proceedings* from 1855 to 1911.[11]

The Fountain* or *Hydropathic Journal. Published at Morristown in 1846.[11]

The New Jersey Association of Osteopathic Physicians and Surgeons. The Association was organized in 1901. It published a *Bulletin* from 1901 to 1963 when it became the *Journal* of the Association.[11]

The New Jersey State Dental Society. The Society has published *Transactions* or *Proceedings* since 1870. Their journal was called the *New Jersey Dental Journal* from 1912 to 1919; in 1929, the curre monthly *Journal of the New Jersey State Dental S ciety* started.[11]

Auxiliary of the Medical Society of New Jerse The Women's Auxiliary to the Medical Society of Ne Jersey was organized at the Annual Meeting in Atlant City on June 17 to 19, 1926; the name later w changed by dropping "Women's." Although the Au iliary did not publish a journal, their Primer *(The Bl Book)* encouraged the members to read *The Journ* of the Medical Society of New Jersey and the offici organ of the Women's Auxiliary to the American Med cal Association called *The Journal* and published sin 1928. They also were encouraged to read the AM magazine *Hygeia* (now called *Today's Health).*[13] September 1948, the Auxiliary *Newsletter* was i itiated and has been published ever since. Present titled *The Shingle*, it is published three times a yea its editor is Mrs. Thomas H. McGlade, and associa editor is Mrs. Ralph Fioretti.

Health Hints; Junior Health Hints. These publ cations were prepared as a public service by the Su committee on Public Relations of the Medical Socie of New Jersey under the editorship of Richard I. Nevi Executive Officer. Each issue contained papers i tended for classroom presentation.

SUMMARY

The history of medicine, medical education, medic organizations, and the history of medical journalis in New Jersey is rich and illustrious. Our olde journals and periodicals are a storehouse of interes ing and stimulating material which spans two-and- half centuries.

REFERENCES

1. Wickes S: *History of Medicine in New Jersey and I Medical Men.* Newark, NJ, Martin R. Dennis & Co., 1879, p 14-15, p. 37, pp. 89-98, p. 234.

2. McClenahan RL: New Jersey medical history in the c onial period. *Proceedings New Jersey Historical Society*, p 362-374.

3. *Transactions, Med Soc NJ* 1776, pp. 3-4, p. 9, 184 1859, 1861, 1893.

4. New Jersey Medical Reporter and Transactions of t New Jersey Medical Society. Burlington, NJ, 1848.

5. *The Medical and Surgical Reporter.* D.G. Brinton, M (ed). Philadelphia, PA, December 1873 to July 1874, p. 6

6. *J Med Soc NJ* Vol. 1. Richard Cole Newton (ed). Newar NJ, September 1904-June 1905.

7. First Annual Report of the State Board of Medical Exar iners of New Jersey. Trenton, 1891.

8. Saffron MH: *A History of the Academy of Medicine New Jersey, 1911-1981.* Lawrenceville, NJ 1981, p. 3.

9. Bulletin, AMNJ, 1955-1970.

10. Benson DS: Highlights of the history of public heal in New Jersey: *Public Health News* 45:165-169, 1964.

11. Cowen DL: *Medicine and Health in New Jersey: History.* Princeton, NJ, D. Van Nostrand Company, Inc., 196

12. Cowen DL: Fifty years of the New Jersey journal pharmacy. *New Jersey Journal of Pharmacy* 50:14-17, 197

13. Rogers F, Sayre AR: *The Healing Art.* Trenton, NJ, Mec cal Society of New Jersey, 1966.

Find your doctor is the headline in what has to be one of the largest posters ever produced—three feet by five.

This poster is in fact a directory of the approximately 10,000 Participating P.A.C.E. Physicians and Providers.

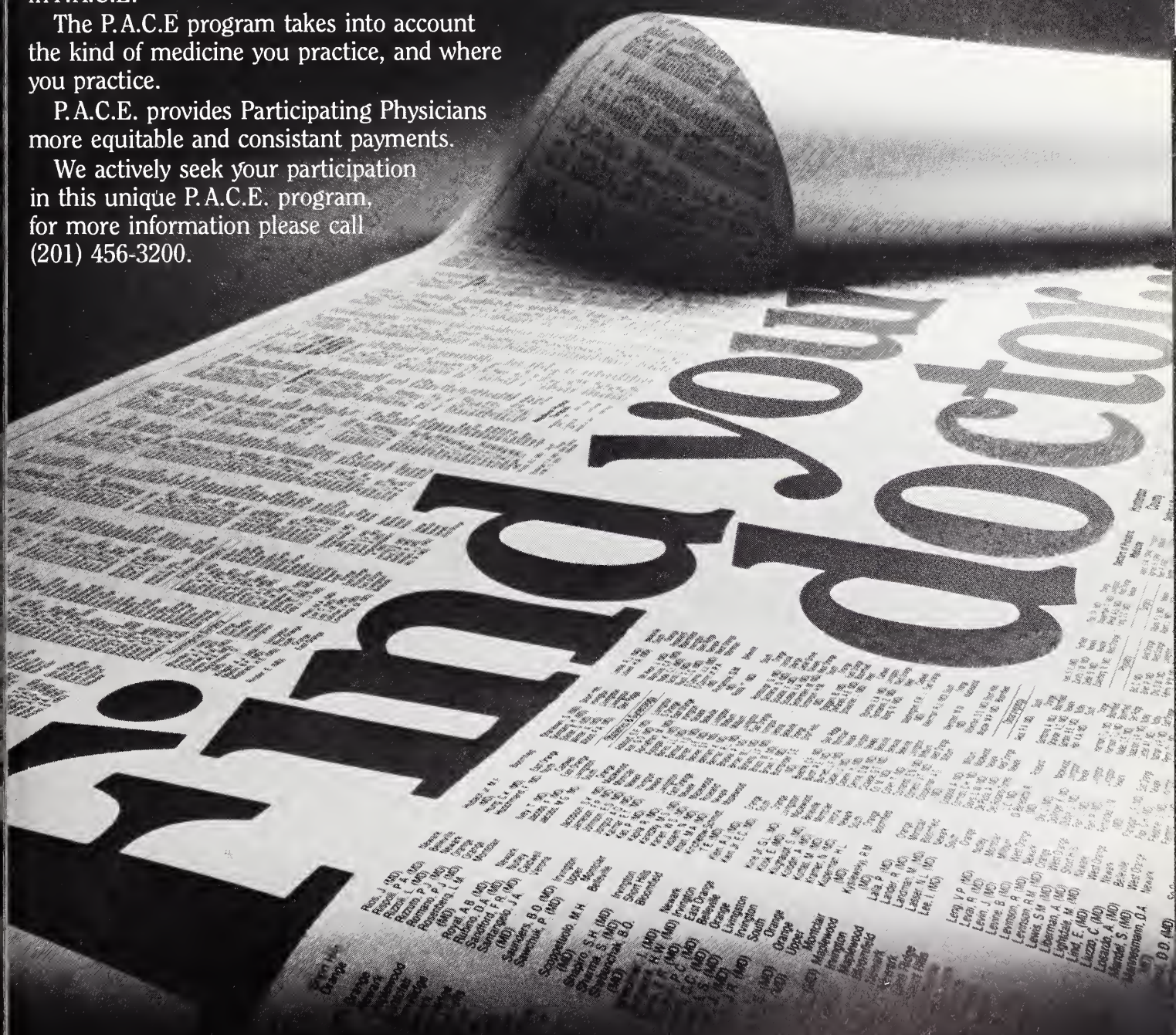
Distributed to 10,000 of our larger P.A.C.E subscriber businesses, it has proven to be a unique and effective way to promote participation, and the key role the Participating Doctor plays in this comprehensive health care coverage.

Currently seven out of ten of your colleagues are participating in P.A.C.E.

The P.A.C.E program takes into account the kind of medicine you practice, and where you practice.

P.A.C.E. provides Participating Physicians more equitable and consistant payments.

We actively seek your participation in this unique P.A.C.E. program, for more information please call (201) 456-3200.



The card that you can count on...

Blue Shield
of New Jersey

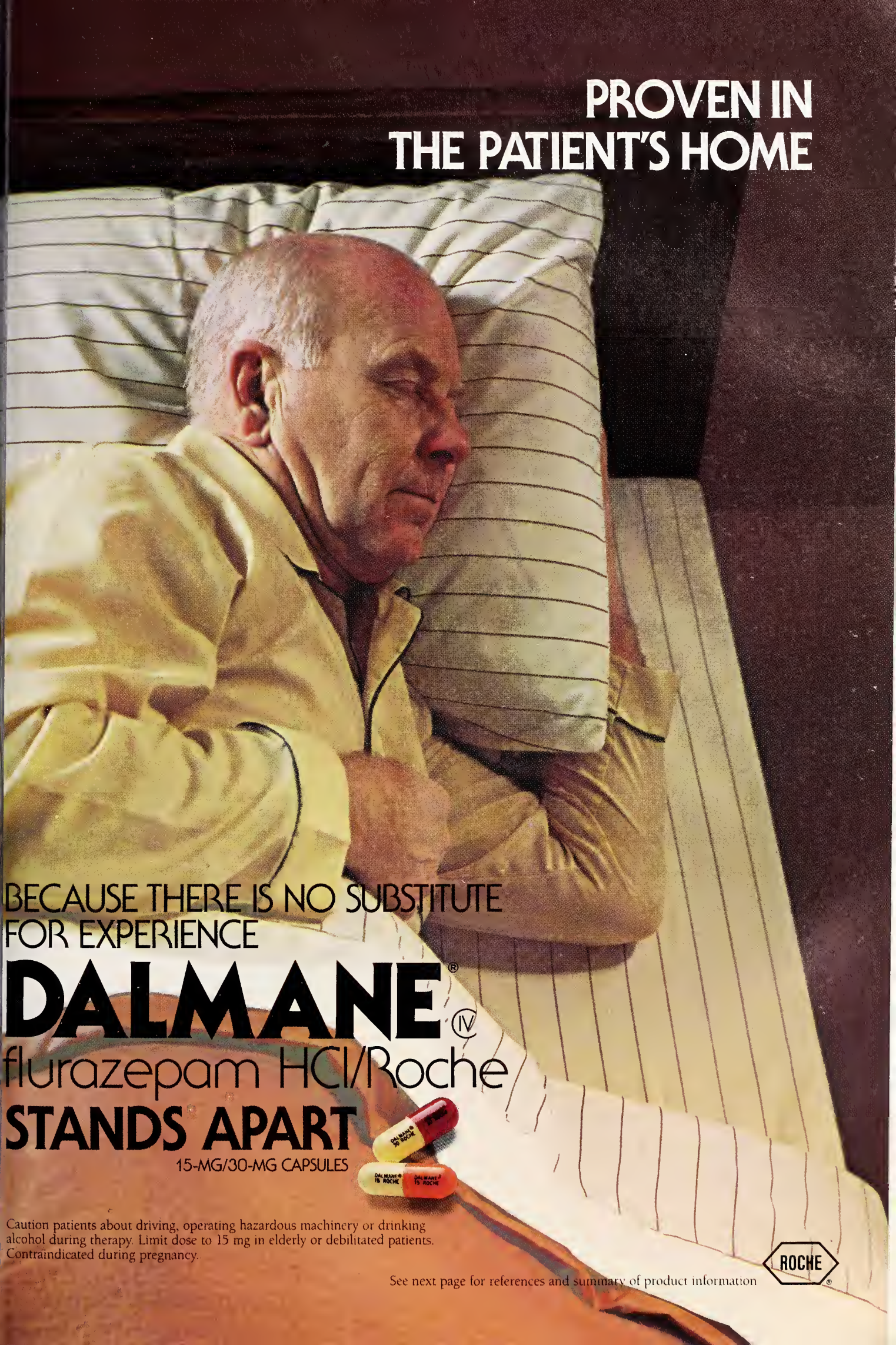
DOCUMENTED IN THE SLEEP LABORATORY[1-5]...



ONLY DALMANE (flurazepam HCl/Roche PROVIDES ALL THESE BENEFITS FOR RESTFUL SLEEP

- Rapid sleep onset[1]
- More total time asleep[1]
- Undiminished efficacy for at least 28 consecutive nights[2]
- Patients usually awake rested and refreshed[7]
- Avoids causing early awakenings or rebound insomnia after discontinuation[2,5,10-

Copyright © 1984 by Roche Products Inc. All rights reserved.


PROVEN IN
THE PATIENT'S HOME
BECAUSE THERE IS NO SUBSTITUTE
FOR EXPERIENCE
DALMANE®
flurazepam HCl/Roche
STANDS APART
15-MG/30-MG CAPSULES
Caution patients about driving, operating hazardous machinery or drinking alcohol during therapy. Limit dose to 15 mg in elderly or debilitated patients. Contraindicated during pregnancy.
See next page for references and summary of product information
ROCHE

DALMANE® (Ⓝ)
flurazepam HCl/Roche

References: **1.** Kales J *et al*: *Clin Pharmacol Ther* 12:691-697, Jul-Aug 1971. **2.** Kales A *et al*: *Clin Pharmacol Ther* 18:356-363, Sep 1975. **3.** Kales A *et al*: *Clin Pharmacol Ther* 19:576-583, May 1976. **4.** Kales A *et al*: *Clin Pharmacol Ther* 32:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol* 3:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther* 21:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. **9.** Amrein R *et al*: *Drugs Exp Clin Res* 9(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol* 3:303-326, May 1981. **11.** Greenblatt DJ *et al*: *Sleep* 5(Suppl 1):S18-S27, 1982. **12.** Kales A *et al*: *Pharmacology* 26:121-137, 1983.

DALMANE® (Ⓝ)
flurazepam HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

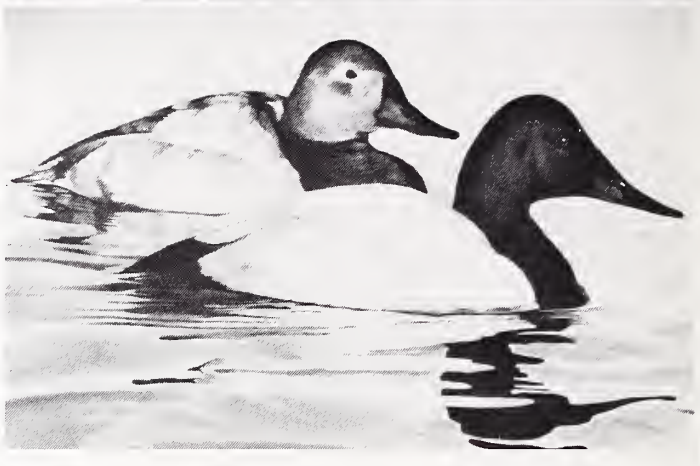
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

"FIRST OF STATE" 1984 NEW JERSEY DUCK STAMP PRINT



Federal and state duck stamp prints are among the most desired collections in the U.S. The federal program is now 51 years old and is worth in excess of $80,000.00! A complete set of "first of state" duck stamp print is worth $16,000.00! Now New Jersey is offering their "first". The design is of a pair of Canvasbacks resting in water. Tom Hirata's painting is crisp, clear and classic!

A framed New Jersey Duck Stamp Print is a perfect addition to your home or office.

Call collect (609) 983-3771

Ask published and national authority Joe McCaddin for the possible tax advantages in collecting duck stamp prints.

MARLTON SPORT 'N WILDLIFE GALLERY



2 North Maple Ave.
Marlton, NJ 08053
(609) 983-3771

Print with two mint stamps $142.50 _____
Executive "color" Remarque Edition w/mints w/signed w/medallion & rem. $561.50 _____

**Framing—Two stamp openings $ 80.00*
Executive Edition $110.00

Mail Order—Add $7.50 for framed UPS delivery
Add $5.00 for unframed UPS delivery

Signature _____
Name _____ Phone _____
Address _____
City _____ State _____ Zip _____
Credit Card # _____ Exp. Date _____

VISA/MC Accepted

*All matting is to museum specifications with hand-stained Walnut. Medallion editions will be framed in Mahogany with gold lip to accent the medallion.

Preliminary Report of Yellow Fever During the 18th Century*

William J. Snape, M.D., Haddonfield
Edward L. Wolfe, Ph.D., Pitman

Written evidence suggests yellow fever existed in the 18th century. The source of infection was watermen who plied the creeks and rivers to Philadelphia and infected Philadelphia fugitives who, for prophylactic or therapeutic reasons, sought refuge in southern New Jersey.

Despite the frequent notice of those calamitous epidemics of yellow fever that ravaged Philadelphia in the closing years of the 18th century, very little information readily is available concerning the effects of this pestilence on neighboring New Jersey. The several histories of the counties of the lower half of New Jersey that were published in the last half of the 19th century make little or no mention of the disorder.[1-3] In spite of such silence, it seemed reasonable to assume that West Jersey should especially have been vulnerable to contamination not only because of its proximity and its social, religious, and economic dependence upon Philadelphia, but also the consequent social interaction between the two communities. Not surprisingly, a search of representative letters, diaries, day books, and medical treatises reveals enough documentation of yellow fever to justify a summary notice of its effects on the lower counties.

Although some of the outbreaks of the disorder were sufficiently severe to desolate small settlements along the creeks and rivers of West Jersey, the inaccessibility of the records of these outbreaks has led to the apparently reasonable conclusion that the area escaped the several attacks of the disease even as it ravaged Philadelphia.[4] Such a conclusion, unfortunately, is quite false.

West Jersey, at that time, was composed of the territory now known as Burlington, Camden, Gloucester, Cumberland, Salem, and Cape May Counties, an area of slightly over 3,000 square miles[5] inhabited by about 53,000 people.[6] Thus, the population concentration was very low.

In contrast, at the time of the 1793 epidemic, the city of Philadelphia was confined within an area that extended only nine blocks along the Delaware River and did not extend much beyond Independence Hall.[7] It was in this congested, unsanitary area that most of the susceptible 50,000 population was crowded into streets, alleys, and courts. About 4,000 persons died of the pestilence.

Although the sparse settlement of West Jersey surely inhibited the spread of yellow fever, it did not prevent outbreaks of the disease.

In 1700, following the first disastrous epidemic in Philadelphia, there was another milder attack of yellow fever that killed 40 settlers "on the two sides of the river," according to William Penn.[8]

Moreover, Cowen noted yellow fever was present in Burlington County in 1746, at a time when it generally was not known to be extant in Philadelphia.[9]

In 1793, John Hunt's diary specifically identified only one case of yellow fever in Burlington County.[10] The diary noted that Sara White died at N. Barton's, of the "fever." Two days earlier, however, "10th month,

*Presented to the Medical History Society of New Jersey on May 18, 1983. Correspondence may be addressed to Dr. Snape, 261 Moore Lane, Haddonfield, NJ 08033.

1st day," Hunt recorded that "many people in the country as well as the city died of the fever." Again, in 1798, Hunt noted on September 1 that "the epidemic is very mortal in Philadelphia and the greater part of the inhabitants is fled and it is in Burlington ... and that it's at Morrises River very mortal 12 died in 11 days and we hear that divers had died on the highways, in the woods, barns, and at Moorestown several buried last week with that disorder." That Hunt moved from reporting on Philadelphians fleeing to Burlington to reporting on the "divers" who "died on the highways" seems to indicate that some of those who died were fugitives from Philadelphia. Fugitives from epidemics often could find no habitation for their last hours of life and expired along the highways, in woods, or in barns.

Mathew Carey,[11] in his brief account of the 1793 epidemic, and Elizabeth Drinker,[12] the charming Quaker diarist, noted the wife and daughter of Joseph Morgan died of yellow fever at Pensaucon (Pennsauken) Creek in what now is the northern portion of Camden County. The diarist noted another Quaker, Samuel Cooper's son, was "dead at ye Ferry," undoubtedly Cooper Ferry, which was the former name of part of Camden City. Mrs. Drinker also made mention of the death of "one Vincent M. Pelosi." Mr. Pelosi lived at what now is Second and Cooper Streets, Camden. In the 1798 epidemic, Condie and Folwell mentioned 26 deaths at Cooper Ferry.[13]

Haddonfield, which at this time was one of the four or five villages of this area and certainly was the social and commercial center, surprisingly has little documentation of yellow fever. Although there is mention of smallpox, cholera, and typhus fever, there is no mention of yellow fever in the memoirs of Bowman Hendry, the physician of the town.[14] Yet, Haddonfield should have been susceptible to the spread of the fever. There was at least one very busy landing on the Cooper Creek (now River), and it was on the Ferry Road connecting South Jersey to Philadelphia at Cooper's Ferry. Moreover, it acted as a transportation terminus for the surrounding backcountry.

John Clement, in his scrapbook, briefly mentioned that yellow fever occasionally was present in Haddonfield.[15] Mathew Carey, in his account of the 1793 epidemic, noted there were infected refugees in Haddonfield, some of whom apparently expired.[11] He believed that the disease was not transmitted to the local residents in these instances. Samuel Mickle mentioned in his 1798 diary: "Some people died at Haddonfield with yellow fever."[16] Neither Carey nor Mickle, unfortunately, provided specific details.

Gloucester, now Gloucester City, was at the time of the epidemics, receding in importance since losing the county seat to Woodbury. We know that at least two infected refugees were there in 1793. Samuel Mickle related that one of these unfortunates died. His name is unknown as are any facts about him except that he died "back of the schoolhouse."[16] The other refugee was the Reverend Dr. Robert Blackwell, who was prominent in Philadelphia social circles. He was the last Anglican missionary in West Jersey and served in a dual capacity of acting Continental Surgeon and chaplain at Valley Forge. Despite his confinement in New Jersey, he was treated daily by Dr. Benjamin Rush's associates. Dr. Rush's letters regarding hi treatment are enlightening in regard to the therapy c the period.[17]

Woodbury and its environs were assaulted by th fever in 1793, 1797, and 1798. It is uncertain whethe there were more yellow fever cases in Woodbury tha elsewhere during this period or whether more evidenc for its existence has persisted. The diarist Samue Mickle, who had what appears to be morbid interes in disease and death, left some details of the pestilen tial visitation. Not only does his diary provide interest ing statistics of yellow fever and other diseases, but hi daybook supplies unusual details of some of the out breaks. Letters from Dr. William Lummis, of Wood bury,[18] and Dr. James Stratton, of Swedesborough, give evidence of the local incidence of yellow fever i Gloucester County. The report of John Otto publishe in Benjamin Rush's volume, *Inquiries*,[20] documente a large outbreak of the disease and its associate climatic conditions in 1797 at Red Bank, which is onl three miles west of Woodbury. Noah Webster[21] als described this outbreak that caused at least ten death in the settlement.[22]

Mickle documented 18 cases in the 1793 epidemi in Woodbury and the neighboring county and an equa number in 1798. Mr. Mickle mentioned 5 cases o Timber Creek, 3 cases at Thompson Point (Paulsboro Haddonfield, and deaths at Carpenter's Bridge (Man tua). He noted that Joseph Sloan, a Quaker, died an was buried in Newton, some 40 miles away. Accordin to John Hunt's diary, there were 11 deaths at Po Elizabeth on the Maurice River. Dr. Stratton describe outbreaks at Carpenter's Bridge (Mantua) and at Old man Creek. In both cases, the infection was brough from Philadelphia by watermen.[19] Dr. Jonathan Elme described cases and deaths in Bridgeton, on th Cohansey River.[23] In the 1798 epidemic, Condie an Folwell listed 26 deaths of yellow fever at Chews Lan ing on the Timber Creek.

Fugitives from epidemics often could find no habitation in their last hours of life and expired along the highways.

One of the interesting theories propounded by D Rush was that infected fugitives did not communicat the disease to exposed inhabitants. The following case seem to cast doubt on Dr. Rush's theory. In the fall c 1797, Dr. John Otto, a Philadelphia physician who ha family ties in Gloucester County, studied a seriou outbreak of yellow fever at Red Bank, a farming com munity of five families. It is believed that 29 person sickened and several died. In August of 1798, Dr. Ott contracted yellow fever and sought refuge in Woodbur at the home of Dr. George Campbell.[16] Although D Otto recovered, Dr. Campbell took the disorder an died. Likewise Mrs. Hopper, who lived near Woodbur nursed a fugitive from Philadelphia. She expired as di two of her children. Dr. Stratton reported an instanc where watermen went to Philadelphia fro

arpenter's Landing. While in Philadelphia, they be-ame intoxicated and went into Southwark and helped lace victims into coffins. They returned to Carpenter's anding (Mantua) and in four or five days sickened nd died, but not before transmitting the disease to everal others of the community, some of whom ex-ired.[19]

The 1798 epidemic was characterized not only by its rulence but also by its extensive spread along the astern seaboard. Portsmouth, Boston, Newport, New ork, Virginia, Baltimore, and Wilmington were at-acked by the pestilence. Wilmington was gravely as-aulted; 252 people succumbed. A Miss Sally Harding ed from Wilmington to her uncle, a Mr. Peterson. His ome was in "Cove," which was about three miles bove what is now Pennsgrove, New Jersey. About a eek later she developed the symptoms of yellow fever ut recovered. Her uncle contracted the disorder and so recovered after a serious illness. Her nurse, how-ver, succumbed to the infection, as did one of her sitors, a Mr. Miller, a medical student.[13] According to ondie and Folwell, there also were cases of yellow fever this time in Trenton and Lumberton.[13]

ONCLUSION

From this review of various primary sources, it is pparent that yellow fever existed in New Jersey in 793, 1797, and 1798. Some of the outbreaks were latively severe considering the sparsity of the popu-tion.

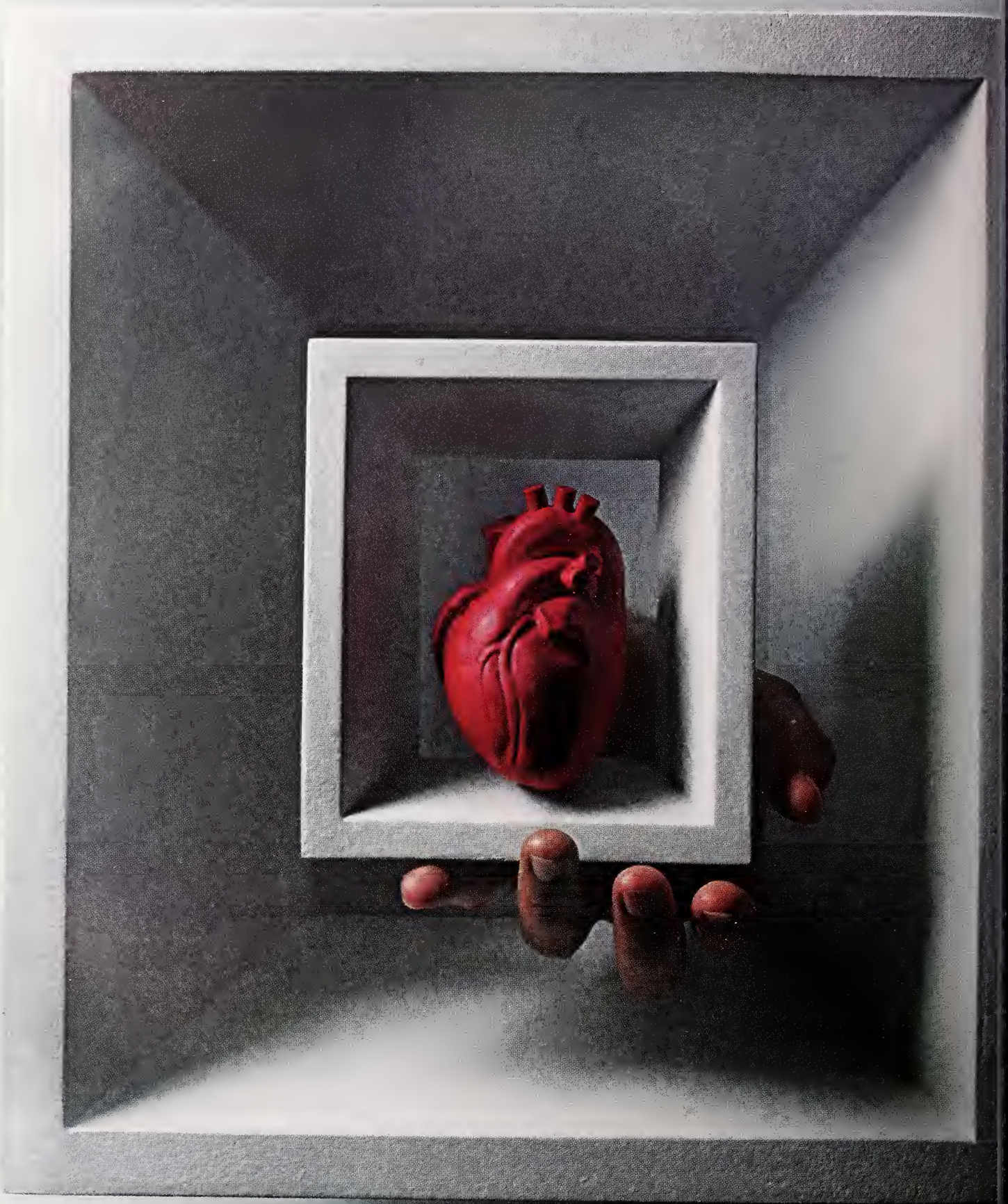
The evidence suggests that the infection was com-unicated to the population of West Jersey by water-en who plied the creeks and rivers to Philadelphia, nd by infected Philadelphia fugitives who, for pro-hylactic purposes or even for therapeutic reasons, ought refuge in southern New Jersey.

There is scattered evidence that yellow fever was resent in New Jersey in the 18th century and con-nued investigation perhaps will reveal it was, con-dering the sparse population, quite prevalent.

The lack of recognition of the degree of involvement West Jersey probably was due to (1) the primitive ulture and governmental organization at that time; nd (2) the dreadful desolation that involved Philadel-hia, which was then the medical center of the North merican continent, made the outbreaks in South Jer-sey seem relatively insignificant.

REFERENCES

1. Cushing T: *History of the Counties of Gloucester, Salem, and Cumberland, New Jersey.* Philadelphia, PA, Everts and Peck, 1883.
2. Prowell GR: *The History of Camden County, New Jersey.* Philadelphia, PA, L.J. Richards and Co., 1886.
3. Woodward EM: *History of Burlington County, New Jersey.* Philadelphia, PA, Everts & Peck, 1883.
4. Cowen DL: *Medicine and Health in New Jersey.* Princeton, NJ, C. Van Nostrand Co., Inc., 1964, p. 41.
5. Murphy JL: *Compendium of Censuses, 1726-1905,* State of New Jersey. Trenton, NJ, 1906.
6. Gordon TF: *Gazeteer of New Jersey, Daniel Fenton.* Trenton, NJ, 1834.
7. Weigley RF (ed): *Philadelphia, A 300-Year History.* New York, NY, W.W. Norton Co., 1982, P. 172.
8. Bronner EB: *William Penn's Holy Experiment.* Philadelphia, PA, Temple University Publications, 1962.
9. Cowen DL: *Medicine and Health in New Jersey.* Princeton, NJ. C. Van Nostrand Co., Inc., 1961, p. 2.
10. *John Hunt Diary,* 1788 to 1800, volume 3.
11. Carey, M: *A Short Account of the Malignant Fever Lately Prevalent in Philadelphia, 4th edition.* Printed by author, 1794, p. 81-82.
12. Biddle HD (ed): *Extracts from the Journal of Elizabeth Drinker, 1759 to 1807.* Philadelphia, PA, J.B. Lippincott Co., 1889, p. 197, 204, 209.
13. Condie T, Folwell R: *History of the Pestilence Commonly Called Yellow Fever Which Almost Desolated Philadelphia.* Philadelphia, PA, 1798, p. 97.
14. *Memoir of Bowman Hendry, M.D. Late of Gloucester County, New Jersey, by a Physician.* Philadelphia, PA, King & Baird, 1848.
15. Clement, J: *Sketches of the Village of Haddonfield, New Jersey.* Manuscript, 1844.
16. Mickle S: *Samuel Mickle Diary,* 1792-1812, p. 38, p. 73, p. 76.
17. Butterfield LH (ed): *Letters of Benjamin Rush, Vol I and Vol II.* Philadelphia, PA, The American Philosophical Society and Princeton University Press, 1951, p. 718-723.
18. Hardie J: An Account of the Malignant Fever Lately Prevalent in New York, 1798, p. 36.
19. Stratton J: Letter to Dr. Joseph Griffitts. Manuscript collection at Philadelphia College of Physicians.
20. Otto J: *Benjamin Rush Medical Inquiries and Observations, Volume V.* Philadelphia, PA, Thomas Dobson, 1798, p. 95.
21. Webster N: *A Brief History of Epidemics and Pestilential Diseases.* Hartford, CT, Hudson and Goodwin, 1799, p. 319.
22. Mickle S: *Samuel Mickle's Daybook of Accounts.*
23. Elmer LQC: *The Constitution and Government of the Province and State of New Jersey.* Newark, NJ, Martin R. Dennis and Co., 1872, p. 416.



Angina Protection with Benefits for a Lifetime

ONCE-DAILY CONTROL WITH HEART-SAVING BENEFITS

By reducing heart rate and cardiac contractility, INDERAL LA helps protect the heart from the potentially serious and debilitating consequences of ischemia. A highly effective antianginal agent for around-the-clock control of symptoms, INDERAL LA also provides cardiovascular protection for a sense of security in the years ahead.

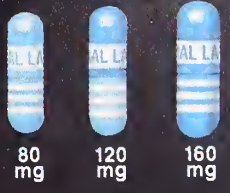
PROTECTION AND EXPERIENCE NO CALCIUM BLOCKER CAN MATCH

Unlike calcium blockers, INDERAL LA—either alone or with a nitrate—is recommended for early treatment of angina in the majority of patients. Equally important, INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use.

START WITH 80 MG ONCE DAILY

Dosage may be increased to 160 mg once daily, as needed, to achieve optimal control. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY **INDERAL® LA**
(PROPRANOLOL HCl) *LONG ACTING CAPSULES*



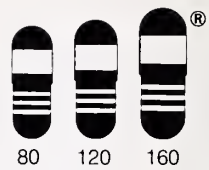
Ayerst®

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

JUST ONCE EACH DAY FOR SIMPLIFIED CORE THERAPY IN ANGINA

ONCE-DAILY

INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking the prior to major surgery is controversial. It should be noted, however, that the impaired abi the heart to respond to reflex adrenergic stimuli may augment the risks of general anesti and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of receptor agonists and its effects can be reversed by administration of such agents, dobutamine or isoproterenol. However, such patients may be subject to protracted s hypotension. Difficulty in starting and maintaining the heartbeat has also been reportec beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the pearance of certain premonitory signs and symptoms (pulse rate and pressure change acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroi Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symp of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function t

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have l reported in which, after propranolol, the tachycardia was replaced by a severe bradyc requiring a demand pacemaker. In one case this resulted after an initial dose of 5 propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with imp hepatic or renal function. INDERAL is not indicated for the treatment of hyperter emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Pat should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart dise elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as r pine should be closely observed if INDERAL is administered. The added catecholan blocking action may produce an excessive reduction of resting sympathetic nervous ac which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthos hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals h been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studi both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of signifi drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dos levels. Reproductive studies in animals did not show any impairment of fertility that attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotox animal studies at doses about 10 times greater than the maximum recommended human d

There are no adequate and well-controlled studies in pregnant women. INDERAL sh be used during pregnancy only if the potential benefit justifies the potential risk to the fe

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised w INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and h rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; h tension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually o Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insom lassitude, weakness, fatigue; reversible mental depression progressing to catatonia, vi disturbances; hallucinations; an acute reversible syndrome characterized by disorientatio time and place, short-term memory loss, emotional lability, slightly clouded sensorium, decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrl constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with ach and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytope purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has b reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male in tence, and Peyronie's disease have been reported rarely. Oculomucocutaneous react involving the skin, serous membranes and conjunctivae reported for a beta blocker (pract have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride sustained-release capsule for administration once daily. If patients are switched from INDE tablets to INDERAL LA capsules, care should be taken to assure that the desired therape effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration r be necessary especially to maintain effectiveness at the end of the 24-hour dosing inte

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may increased to 120 mg once daily or higher until adequate blood-pressure control is achie The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of mg may be required. The time needed for full hypertensive response to a given dosag variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL once daily, dosage should be gradually increased at three to seven day intervals until optim response is obtained. Although individual patients may respond at any dosage level, average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few we (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL once daily. The usual effective dose range is 160-240 mg once daily. The dosage may increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is obtained within four to six weeks after reaching the maximum dose, INDERAL LA ther should be discontinued. It may be advisable to withdraw the drug gradually over a perio several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.
PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laborator

8833/3

Ayerst® AYERST LABORATORIES
New York, N.Y. 10017

The History of Medicine and Medical Care in New Brunswick

Norman Reitman, M.D., Highland Park*

The evolution of medicine in New Brunswick from colonial times to the present is discussed. A brief history of medical education as it involved historic Queens College, now Rutgers University, is given. The development of health facilities in New Brunswick is noted.

At the time of the 13 original colonies, the total number of practitioners of medicine was 3,500. Four hundred practitioners had formal training and 200 of them earned a medical degree. The University of Pennsylvania, one of the first medical schools in the United States, graduated its first class in 1768. There were ten graduates, one of whom came from New Jersey. At the end of the 18th century, there were 300 practitioners in New Jersey, of whom 41 had earned medical degrees.

Three categories of practitioners existed in the colonies at that time. The first were those who had earned degrees in Europe, England, Ireland, or Scotland, and a few who graduated from the University of Pennsylvania. The second and most common group were those students apprenticed to established physicians who spent a varying period of time with them and then went into their own practices, having learned medicine the pragmatic way. Finally, there were the practitioners who, for the most part, were self-trained and who lived in various outlying settlements and communities throughout the colonies and practiced a sort of herbal or folk medicine.

The first record of a physician in the New Brunswick area is that of Dr. Henry Greenland who practiced from 1670 to 1706. His office was on the east side of the Raritan River, in what is now Highland Park. Not uncommon in those days, he also owned a local tavern. The first course of medical instruction given in the New Brunswick area was by Dr. Thomas Wood, who gave a course in osteology and myology in 1752.

DEVELOPMENT OF MEDICINE

The catalyst for the development of medicine in this area goes back to the French and Indian Wars (1756 to 1763). New Brunswick was the staging area for the British Expeditionary Force in that conflict. The barracks were at Newark, New Brunswick, Morristown, and Trenton. The British troops based here were accompanied by their medical units consisting of the medical officers and the corpsmen. They kept the soldiers who were ill or injured in the barracks, and for the first time the local physicians saw the modern medicine of the day practiced by the British Medical Corps.

On April 14, 1766, in New Brunswick, the Medical Society of New Jersey was organized at Duff's Tavern, a well-known landmark on the west bank of the Raritan River. It was the first medical society in the American colonies. The Middlesex County Medical Society also was founded in that same year.

PRACTICING PHYSICIANS

Another significant medical event is associated with

*Dr. Reitman is a Clinical Professor of Medicine, UMDNJ-Rutgers Medical School.

New Brunswick—the licensure of physicians. In those early days, almost anyone who wished to practice the healing art could do so. In 1772, Dr. John Cochran, an outstanding New Brunswick physician in the colonial and revolutionary period, was instrumental in seeking the passage of a bill "to regulate the practice of physic and surgery within the colony of New Jersey" by the colonial legislature. This represented the first licensing of physicians in our state. Those who wished to qualify were examined by the Medical Society and then were licensed by the Supreme Court of the Colonies. This was the only licensing body in existence at that time. Later, the state organized a Board of Medical Examiners under the Medical Society of New Jersey, which was responsible for licensing of the physicians.

Dr. Cochran was very active in many other professional activities in that era. A friend and confidante of Generals Washington and Lafayette, he eventually became the Director General of Hospitals for the Continental Army. He was instrumental in organizing a smallpox vaccination program in the New Brunswick area and it is recorded that in 1774 he vaccinated 400 people in New Brunswick with no deaths. He also served as the third President of the Medical Society of New Jersey.

Other prominent New Brunswick physicians during the Revolution were Drs. Moses Scott and John Van Cleve. Dr. Scott served as Chief Surgeon of the Continental Army Hospital in Piscataway. Dr. Van Cleve, a Princeton alumnus and trustee, attempted to establish a medical school at Princeton; he died before his ambitions could be realized.

Dr. Charles Smith was the first student to get a medical degree from Queens College in 1798. He later became a trustee of Queens College, which in 1825 became Rutgers College.

An interesting personality during the 1840s was Dr. Augustus Taylor, practicing physician, mayor of New Brunswick, and certified sea captain who sailed around Cape Horn to California and the west coast of the Americas many times. In his diary of March 3, 1838, he speaks of "establishing a dispensary for the purpose of prescribing and furnishing medicine gratuitously to the poor." He quotes the famous English physician, Suydenham, who said "the poor were his best patients because God was their paymaster."

In 1850, another local physician, Dr. Hollingshead, was concerned about the fate of the insane and established an asylum for the insane under state or municipal auspices. This was the forerunner of today's State Department of Institutions and Agencies.

In 1885, Dr. Henry Rutgers Baldwin founded the Wells Memorial Hospital which was later to become Middlesex General Hospital and in 1907, Dr. Francis Donohue with Monsignor O'Grady founded what today is St. Peter's Medical Center.

HOSPITAL CARE

The development of hospitals in this area is interesting. Records show that in April 1872, the City Council considered a New Brunswick Hospital Board but it never materialized. In the same year, the Franciscan Sisters from Loretto, Pennsylvania, came to New Brunswick and established St. Peter's General Hospital. The hospital was closed for economic reasons after two years; however the building was re-opened as an orphan asylum and home for the aged several years after that. In 1884, a New Brunswick City Hospital was started as a contagious disease facility where patients could be kept when they had infectious diseases. The following year when the Wells Memorial Hospital was built on Somerset Street, the New Brunswick City Hospital became part of the Wells Memorial Hospital. The original Wells building stood on the site of the present Robert Wood Johnson Tower of Middlesex General-University Hospital and for years was known as the Wells Building. It served as part of the hospital facility as recently as 1968.

In 1907, St. Peter's General Hospital was founded and minutes of the trustees' meetings exist from that time. In 1917, Wells Memorial Hospital became the Middlesex General Hospital; in 1926, the Brown Street addition was built, giving Middlesex 100 beds. In 1929, St. Peter's General Hospital moved to its present location on Easton Avenue, opposite Buccleuch Park, constructing a modern facility of 220 beds. This was the total number of hospital beds the community had until the mid-1950s when the first joint hospital drive took place. The need to expand both hospitals at the same time prompted the local leaders to organize a combined drive for both institutions. As a result, Middlesex Hospital built its 1958 building which increased the bed capacity to 225. Although considered the most modern facility at the time, it quickly became inadequate and the need for more beds became evident. St. Peter's Hospital built its B and D wings, giving them an additional 100 beds. In 1969, a second combined hospital drive was conducted which resulted in the Robert Wood Johnson Tower addition to Middlesex Hospital, housing a modern laboratory and many more beds. St. Peter's Hospital, likewise, built a new operating suite and another wing for patient care, as well as updating the facilities for its well-known department of radiology.

To complete the record, we have evidence of a corporation in New Brunswick called the New Brunswick Affiliated Hospitals, which existed from 1965 to 1980. In the early 1960s, local hospitals conducted medical residency training programs. These programs were in danger of losing their accreditation because of insufficient numbers of beds and subspecialty services at each institution. A group of physicians, Drs. Gabriel Pickar, Jasper Van Avery, Paul Jennings, and myself undertook to establish a program to operate a combined medical residency. This joint program had enough beds and subspecialty strength for approval. To facilitate this program, we incorporated under the name of the New Brunswick Affiliated Hospitals. For some time, people thought that indeed the two hospitals in New Brunswick were going to combine into one unit but this never came to pass.

The New Brunswick Medical Residency Program functioned successfully; later, it merged with the medical residency programs of UMDNJ-Rutgers Medical School. These programs have become highly successful academic training programs at both institutions.

In 1976, Middlesex General Hospital became the primary teaching hospital of UMDNJ-Rutgers Medical School. Today, Middlesex General-University Hospital

tands as a first-rate academic health science center ombining traditional programs of a community hos- ital, and bringing outstanding health and research acilities to the central New Jersey area.

The role of Johnson & Johnson must be mentioned. ecords of St. Peter's Hospital from 1913 reveal an xpression of thanks to Johnson & Johnson for sup- lying all the bandages and dressings free of charge. or years, the company supplied both hospitals simi- arly. Johnson & Johnson was the leading force to nlarge and equip these hospitals and was mag- animous in promoting education in health care in his area.

EDICAL EDUCATION

In 1792, a well-known practitioner in New York City, r. Nicholas Romaigne, petitioned Queens College to rganize a medical faculty in New York. He had been n the faculty of the College of Physicians and Sur- eons of Columbia University but desired to establish nother institution. As a result, Queens College warded several medical degrees between 1792 and 798. The school then closed but was re-opened in 812, again under the leadership of the same Dr. omaigne. It was known as the Queens College Medical epartment and graduated 21 physicians between 812 and 1816. In 1825, Queens College became utgers College, named after a benefactor, Colonel enry Rutgers. Once again, the Rutgers Medical Col- ge flourished under the leadership of Dr. David osack, a distinguished professor from the College of hysicians and Surgeons. The institution awarded 27 edical degrees from 1826 to 1827. In that year, the egents of the State of New York forbade the issuing f degrees from a college or university that was not censed in that state. From 1827 until 1954, there was no formal medical education in New Jersey although an attempt to establish a medical school in Newark in the 1940s failed.

In 1954, the state legislature supported a bond issue to establish a medical school at Rutgers. This was defeated. However, the momentum to establish a medical school in New Brunswick continued. In 1961, the Kellogg Foundation awarded Rutgers $1,000,000 to develop a two-year medical school program. In 1962, Dr. H. DeWitt Stetten, Jr. was appointed dean and began assembling a faculty. The first class of 16 students was admitted in 1966. Rutgers, the State University, now had its own medical school. An excellent basic science faculty was recruited but plans for clinical facilities and the development of a University Hospital were curtailed when the state legislature in 1970 approved a bill establishing a separate College of Medicine and Dentistry with one component in Newark and one at the Busch Campus of Rutgers. In that same year, the school expanded to a four-year curriculum, graduating its first students in 1972. This institution, now known as the University of Medicine and Dentistry of New Jersey, has grown dramatically in the past 14 years and the Rutgers Medical School component has grown with it. At the present time, there is a student body of over 400 and a large preclinical and clinical faculty based in Piscataway and New Brunswick.

CONCLUSION

New Brunswick—the hub of New Jersey—is poised at the beginning of its fourth century. I am sure that the succeeding years will continue to reveal further achievements by outstanding New Brunswick physicians and institutions to the development of medicine that reaches far beyond the city.

THE LIFE AND TIMES OF CAMDEN

SAM ALEWITZ, PH.D., GLOUCESTER TOWNSHIP*

In the late 19th century, public health programs in Camden city and Camden county were dependent on political and economic experiences. Because of this, disease was commonplace, living conditions were precarious, and poor health was the norm.

Camden county public health programs in the late 19th century were dependent on political and economic experiences. The speed, thoroughness, permanency, and universality with which these programs were implemented may be used as an indicator by which to gauge the sincerity of those politicians and community leaders responsible for the implementation.

Mortality rates were a partial measure of the success of public health activity. They were a useful statistical reference point but did not describe adequately the lack of humanity or the quality of life which affected the health of many of the county residents. While the entire community suffered from the lack of public and private hygiene, the poor generally were the most susceptible victims. They had few friends in public service, private charity, and in the professions. The county and city medical societies were responsive to the public health needs of the community when disease threatened and, at critical moments, served to arouse the politicians to take positive action; however, they did not sustain these activities over extended periods of time.

CONDITIONS IN CAMDEN

The public health projects which were undertaken in Camden county and Camden city before the mid-1880s were restricted to the most basic and primitive sanitary measures. Public and private welfare was doled out reluctantly and with apprehension. The meager charity provided to the poor resulted in a subsistence standard of living which left them in poor health and exposed to the ravages of disease.

Buttressed by social, economic, and medical misrepresentations and myths, Camden county and municipal officials, with the public's approval, were indifferent to the needs and often dangerously negligent in their duty to provide basic hygienic and health services. The officials ignored the high death rate and, optimistically, expected that the excellent geographical location of Camden, the absence of overcrowded tenements, economic growth, and greater employment opportunities would serve to provide good health.[1-4]

Camden public officials tended to minimize the extent of the risk from threatening diseases and did nothing until it often was too late. Endemic smallpox and enteric diseases, for which there were known preventives, generally were ignored until they reached epidemic proportions. Only the fear of a dreaded cholera epidemic moved county and municipal officials to institute temporary and aggressive public health measures. The lack of attention to the unsanitary conditions and to fundamental humanity was evident in

*Dr. Alewitz earned his Ph.D. in the History Department of Case Western Reserve University in Cleveland, Ohio, after he retired as an engineer who had devoted his career to the improvement of the quality of life and safety in the home.

a number of events which occurred from the end of 1879 until about the middle of 1881.

Camden city, with an area of 6.5 square miles, had doubled its population from 20,045 in 1870 to 41,659 in 1880. Camden was the 4th largest city in the state and the 44th in the United States. Over 9,900 people lived in the next three largest towns and 13,257 lived in 222 square miles of rural countryside. Approximately 85 percent of the population was native born; of the 7,166 foreign born, most were from England, Ireland, and northern Europe. Kaighnsville, a neighborhood of Camden city, had an expanding black community and other black communities were established in surrounding townships. There was a black population of 5,652, approximately 9 percent of the county population.[5,6]

Camden county served as a home for thousands of commuters who worked and shopped in Philadelphia. It also attracted a great many transients, without any prospect of employment, who brought with them potential health problems.[6]

The businessmen and politicians had envisioned the growth of Camden county into a prosperous industrial metropolis. However, the adverse economic conditions of the 1870s caused many Camden county workers to have serious doubts about their future. The New Jersey Bureau of Statistics of Labor and Industry reported that New Jersey unskilled workers earned $412.35 a year, and skilled workers earned $625 a year. However, expenses for a family of five were in excess of $618 a year; a condition which forced many of the Camden workers into debt and left a trail of broken homes.[7]

Hunger was commonplace and starvation was acknowledged publicly. The editor of the *Camden Daily Post* was disturbed by the presence of starvation in Philadelphia and aboard ships carrying immigrants to the United States, but reported, without any emotion or bitterness, starvation in Camden county.[2,8] James Bishop, Chief of the Bureau of Statistics, called the payment of low wages an "abominable doctrine" that led "to strife, poverty, crime, and general demoralization," and attributed the hard times in Camden to an unequal distribution of wealth.[9] Dr. Ezra M. Hunt, secretary of the State Board of Health, further charged that the wage question was not only a problem of pay scale, but the ability of a worker to purchase good health.[10]

PUBLIC AND PRIVATE CONCERNS

In 1880, there were few public or private organizations in Camden county to which the needy could turn for help. In the public sector there was the county poorhouse and meager municipal outdoor relief.[2,8] In 1879 and 1880, the city of Camden reduced its welfare funds from $13,000 to $200. Even with these sharp cuts some residents remained as fearful of relief "cheaters" who, they claimed, would squander these scanty funds as they were of the city employees who had access to these funds.[2,3]

Gloucester city reluctantly allocated $750 for welfare funds for the year 1880. However, they let it be known that the $10,000 paid in taxes to the county provided adequate funds to take care of their poor.[2,3] Responsibility for the burial of the poor, the last act of charity, was a contested issue between the county and Gloucester city, with each refusing to provide the necessary money. There is no evidence that any of the other communities made a more generous contribution for the care of their destitute residents.[2,4]

The *Camden Daily Post* was commended by a group of the "most discriminating citizens" for supporting their position on public charity. This group was convinced of the "shameful waste" of public aid to the poor.[2] This position was not unusual and was in accord with the generally accepted social theories of the period: indiscriminate charity led to pauperism and moral and physical degeneration, which gave rise to hereditary defectives.[2] In a letter to the editor, "Benevolence" expressed the consensus opinion and declared that "the only way to relieve the worthy poor" was through "private benevolence and not with public funds."[2]

In spite of the appeals for private charity, when the State Charities Aid Association of New Jersey was organized, in 1886, to develop acceptable ways to dispense aid to the needy, Camden county was not represented.[2,4] Private philanthropy in the county was limited to orphanages, soup kitchens, sewing groups, Sunday breakfast missions, and personal almsgiving. However, private charity was not offered freely. It was necessary for the press repeatedly to appeal to the humanity of the residents of the county to care for the indigent.[2,4]

On January 16, 1881, the *Philadelphia Times*, without mentioning Camden by name, wrote that there was nothing so pathetic in the world as men and women who were "half sinking in that sea of troubles which is the result of continued poverty."[8] On January 19, 1881, the *West Jersey Press* accused the Philadelphia newspaper of attempting to blackmail the Camden City Council for the purpose of "relieving the suffering poor." The paper rationalized that it would be sheer coincidence that with over 40,000 inhabitants there would be no "want and suffering" and, furthermore, the money was ending up in "pockets of a certain class of officials."[3] Camden's policy towards the poor made the private city of Philadelphia appear generously philanthropic.

SANITARY CONDITIONS

The sanitary conditions in Camden county were primitive. As late as 1886, Camden city, with 60 miles of dedicated streets, reported that only 1 mile was paved in Belgian and asphaltum block; half of the streets were crudely paved, and the remainder of the streets unpaved.[5,6] However, telephone service in Camden city was operative on August 15, 1879, more than a year before the first Belgian block pavement was laid in Federal Street in 1881.[2,12] Only paved streets were contracted to be cleaned, so that approximately 59 miles of streets remained quagmires of filth from overflowing cesspools, culverts, and clogged sewers. Portions of the Seventh and Eighth Ward, where the poor lived, never were cleaned. Pigsties were kept in backyards, animals roamed the streets freely, and the hundreds of horses used for transportation and cartage added to the danger of an already unhealthy environment.[2,3,6,13] Poorly designed and constructed sewers and culverts became elongated cesspools that

festered in the summer heat.[13] Residents of communities with inadequate drainage were plagued with "remittent" fever (malaria). Raw sewage and polluted run-off water were carried into the Delaware River and created a noisome nuisance. Sewage moved upstream by tidal activity from Camden sewer outlets and across the river from Philadelphia into the Camden water supply. The enteric diseases which arose were called "Kensington Diarrhea" in honor of the Philadelphia source of the scourge.[2-4,6] The communities which were not serviced with city water mains were not exempt from these dangers, since their seldom emptied cesspools contaminated the well water.[6]

Gloucester city, with a population of 5,347, the second largest city in the county, was just as unsanitary. A report in the *West Jersey Press* described the city as follows: "The gutter with its concomitant filth lies stagnant and festering, polluting the air around and inoculating with noxious diseases all who have occasion to pass through the streets."[3]

The public health projects which were undertaken before the mid-1880s were restricted to the most basic and sanitary measures.

Housing in Camden, which had a low density of 5.1 persons per home, had been compared favorably by the members of the 1874 New Jersey Health Commission with conditions in Philadelphia, known as the "City of Homes;" while the tenements in Newark, Jersey City, Paterson, and Trenton were compared with the overcrowded and unsanitary housing of the lower east side of New York City.[14] What is significant is that Camden had a death rate of 22.9 per thousand, a rate equal to any of the more populated and overcrowded northern New Jersey cities.[6]

The Camden housing statistics did not paint a realistic picture of housing conditions which existed in the city. Dr. James H. Wroth, in *The Physicians Dispensary Report*, described Kaighnsville, a section of Camden city, as crowded, with families occupying one room which was used for sleeping, eating, and cooking; with no drainage or sewerage system; with water pumps on the street corner near open culverts; and garbage strewn over the unpaved streets.[2,15] Sections of Camden city were repositories of antiquated single homes, long in disrepair, which were inhabited by the poorest classes of native and foreign born. In 1890, Hunt pointed to the bad housing as a cause of "degradation, thriftlessness, sickness, and crime."[16]

In the county and its political subdivisions, public health agencies were nonexistent or noneffective and private medical care was limited. The Camden City Council had established a Sanitary Committee in 1872 but its activity was restricted by local politics. In 1886, the city reluctantly established an independent Board of Health under the direction of a physician but only at the urging of the medical societies and after an 1881 amendment to the state public health law made it mandatory.[2,3,6,17]

MEDICAL CARE

Medical care for the poor of Camden county was a story of tragic neglect. It was only through the work of a few charitable individuals that even the most rudimentary health services were provided. On April 1, 1866, through the efforts of several local businessmen and physicians, a Camden City Dispensary for the "worthy" poor was opened under the management of the Camden City Medical Society. Several years later, a few beds were added as a hospital for the indigent, and to provide emergency services. However, the hospital section soon was closed due to a lack of funds.[17] The Dispensary continued to have a turbulent history: ignored by the county, neglected by the city, and spurned by the public in its efforts to raise funds, only the charity of a few physicians provided the services and money to continue their good works.[2,3,17] In 1879, after it became obvious that the Dispensary would be forced to close, the city agreed to provide minimum funds for drugs and physicians' services.[3,17] Too many died without any medical assistance and as late as 1881, after the city had agreed to pay for some of the services, the *Camden Daily Post* noted the inadequate medical care provided to the Third Medical district which comprised the Seventh and Eighth Wards, home to many of the indigent and working poor.[2]

The Cooper Hospital, endowed by the Cooper family, was incorporated on March 24, 1875, and completed in 1877; however, due to a lack of funds, it was not opened to the public until August 11, 1887. On February 5, 1885, the homeopathic physicians, who had been criticized frequently by the Camden County and Camden City Medical Societies, opened a small hospital comprising two wards as well as an outpatient department. Since private efforts were directed toward the "worthy" poor sick, it remained for the county to provide a "hospital" at the Almshouse for the "unworthy" poor, and this was opened after the typhus epidemic occurred at that county institution.[17]

The social upheaval of the Civil War and the subsequent economic depression of 1873 created an army of transients, many of whom found their way through Camden county because of its crossroad location. They brought with them the seeds of disease and ill health and served as a focal point for arousing fear, hatred, and mistrust. As living proof of the failure of public relief, they were housed in the local jails and county almshouse at the expense of the taxpayers who were averse even to paying for the care of the resident poor. Dr. Hunt, in a study of the problem, estimated that the cost to Camden county was in excess of $20,000 for the period of the typhus epidemic of 1880 to 1881.[6]

On October 28, 1879, the *Syracuse Times* made a startling discovery. It found that the average citizen of New Jersey lived longer and suffered less from sickness in prison than while at liberty.[2] It is highly improbable that the allegations applied to the unsanitary and unsavory Camden county jail which had been under attack as a menace to the health of the prisoners since 1876. In May 1879, the matter was presented to the grand jury which handed down an indictment that charged the Board of Chosen Freeholders with maintaining a jail that was "unwholesome, ill-governed, overcrowded, unfitted, and inadequate."[2-4,18] Long after

his visit to the jail, Dr. Hunt gave vent to his anger and described the conditions as follows: "Garbage long unemptied, beds and cells beyond description, linen unchanged for months, not a towel seen by inmates, and the general condition of the dungeons, the corridors, and the inmates, made it a scene scarcely to be credited but for the number and character of the witnesses."

In addition to strong ideological reasons for denying support to the poor, the behavior of the politicians, press, and many residents stemmed from their conscious efforts to reduce county and municipal expenses. Nowhere was this more obvious than in the actions taken toward those most dependent on the bureaucracy for medical help and humanity: the mentally ill.

THE COUNTY ASYLUM

The County Asylum was opened in 1879. It was established in order to save approximately $6,000 per year by removing county residents from the more costly Trenton State Hospital.[2,3,8] The position of the Freeholders was that since the County Asylum was to be used for incurable patients that it would not be necessary to provide a full-time physician or a professional staff. From the very inception of the project the County Medical Society refused to give its wholehearted approval. Dr. Dowling Benjamin, a member of the Society Asylum Committee, voiced his doubts and disapproval, and Dr. J. M. Ridge, who had served as a member of the New Jersey State Board of Health, had given tentative approval to the establishment of the County Asylum, but finally called the idea "a false measure of economy."[2-4,8] However, the move was applauded by the politicians and business community. Their delight was short lived when rumors of alleged mismanagement and cruelty at the Asylum and Almshouse surfaced and exposed conditions at the institution, to the scrutiny of the public.

On or about October 1, 1879, the Reverend William H. Jeffreys, a Methodist Episcopalian minister with 25 years of service, suffered a nervous breakdown and was admitted to the Camden County Asylum. On October 5, 1879, Nathan T. Mulliner, a well-known and respected Camden businessman and a member of the Camden Masonic Lodge No. 15, which listed among its members many well-known Camden physicians, was found wandering aimlessly in Trenton. He was returned to Camden and admitted to the Asylum. At the time of their admissions, rumors of misconduct and mismanagement at the Almshouse and Asylum surfaced but summarily were investigated and dismissed by the Board of Chosen Freeholders.[2,3]

A few months later the editor of the *Camden Daily Post* found reason to suggest that there was little to fear since "the days of darkness, dungeons, whips, and chains of lunatics" were over.[2] In spite of his assertions, the rumors of inhumane treatment at the Asylum continued to persist and the paper featured a story, "Our Poor and Insane," which detailed a visit by local politicians and physicians to the Asylum. The report included support for the Asylum management and a diagnosis made by Mrs. Stiles, the matron (supervisor), that most of the patients were confined because of paralysis of the brain brought on by inordinate use of tobacco and rum. At the conclusion of their visit, the visitors ate a hearty meal which was provided by the Asylum, no doubt topped off with cigars and wine, "and the gentlemen then went over the hill to the poorhouse for a visit."[2]

After his release from the Asylum in November 1880, Jeffreys publicly charged that the patients were subjected to cruel treatment at the Asylum, and specifically called attention to the beating administered to Mulliner. Because of their social positions in the community, his charges triggered a new series of inquiries into the allegations of mistreatment. On January 8, 1881, Masonic Lodge No. 15 appointed a committee of its members to investigate cruelty at the Asylum and mismanagement at the Almshouse. The report never was made public.[2,8] The following day, the *Philadelphia Times* accused the officials of the County Insane Asylum of conducting an institution with conditions they labeled as "madhouse inhumanity." They alleged that the Asylum personnel was guilty of beating the patients with blackjacks, and that the general conditions were worse than the "filth, foul air, and fatal fever" at the Almshouse.[8]

As a result of the charges which were leveled by the *Philadelphia Times* and the undercurrent that rippled outside of the county boundaries, two Boards of Inquiry were established. The Board of Chosen Freeholders appointed a committee which included two members of the Asylum Committee, and members of the Joint Committee on Lunatic Asylums of the state legislature constituted the second committee.[2-4,8] The investigating committees were established as voluntary bodies, without legal sanction, and it became obvious that the charges made by Jeffreys would not be sustained. Twenty-eight witnesses were heard in three hearings. Only 3 of the witnesses had been patients, and 1 was the wife of a patient. Unfortunately, those most directly involved were not able to testify because of their mental condition.[8,19,20] In the end the Board of Chosen Freeholders exonerated itself, while the state committee, more politically astute, issued a report that found the problem of maltreatment due to inexperience rather than inhumanity, and further recommended that patients first be sent to the Trenton State Asylum for treatment before being declared incurable.[2,4,20,21]

The results were greeted by the Camden press with a display of hometown partisanship. Before the final reports were issued, the local press displayed some concern for the therapeutic needs of the patients and the welfare of the residents of the county. The *West Jersey Press* clearly had enunciated the public view: the Asylum was badly managed, "acts of cruelty were common and drunkenness frequent," and the investigation proved the Freeholders "incapacity" and "unfitness" to run "an institution for which some ideas of humanity" were essential requirements.[3] The state legislature, aware of the problems in the Camden Asylum and in anticipation of the final reports, introduced an act to reform the management of county asylums. They concluded that it would "not do to trifle with life and intellect simply to save a dollar or two."[2]

THE ALMSHOUSE

The conditions and inhumanity at the Asylum were

not an isolated case of neglect by public officials. The exposure of the conditions at the Asylum had been preceded by a smallpox epidemic that raged in Camden city and a typhus epidemic at the Almshouse. The politics of neglect, aided by socioeconomic conditions, and adverse weather, helped turn the Almshouse into a death trap. The extreme cold temperature of November 1880, drove the transients in Camden to seek refuge in the local jails and the Almshouse.[2] The Almshouse, built to house about 150 residents, held approximately 275 men, women, and children. More than a year earlier, complaints had been leveled at the Freeholders for allowing the overcrowded conditions, with the potential for disease, to exist.[3,4,19] On July 11, 1879, at a special meeting of the Freeholders, plans were approved for a needed addition to the Almshouse.[3,22] Unfortunately, the building was not finished in time to help the victims of the typhus epidemic that began at the end of November 1880.

On November 4 or 5, 1880, Henry Brown, a transient laborer from Philadelphia who had worked in Ellisburg (a crossroad village in Camden county), visited his hometown where he roomed in an overcrowded, lice-infested boarding house. On November 11 he returned to Ellisburg. On November 24, Brown, running a high fever and in a semiconscious state, was brought to the Almshouse. His condition was diagnosed as "malarial fever," and because there were no other facilities available, he was placed in a 12 by 12 foot room with three other residents who soon contracted the disease, which then spread throughout the Almshouse. On December 23, the heating boiler, in the new building which had been rushed into service as a hospital, burst and the rooms had to be evacuated because of the cold. This forced the already overcrowded patients and residents into even closer quarters.[6,17]

On January 8, 1881, the *Philadelphia Times* published the first of a series of articles condemning the county officials for creating "a Poor House Plague, of filth, foul air, and dying paupers."[8] With 47 sick and 11 dead, the paper lashed out at the unsanitary conditions and the inhumane treatment of the Almshouse residents. There were suspicions that the disease was typhus fever, on the basis of pathological studies performed by Drs. Henry E. Branin and Joseph W. McCullough. However, Drs. Branin and McCullough, part-time physicians at the Asylum and Almshouse, respectively, continued to address the problem as a "serious and malignant epidemic marked with characteristics of typhoid, typhus, and malarial fever."[6]

Typhus was not confirmed until E. A. Ward, the contractor for the new addition and a well-known politician, was fatally stricken with the disease while at work at the Almshouse. Dr. William Pepper of the University of Pennsylvania was called in as his physician on January 11, 1881, and diagnosed the disease as a virulent typhus. An autopsy performed by two pathologists, Drs. James Tyson and Henry F. Formad from the University of Pennsylvania, later confirmed Dr. Pepper's diagnosis.[2,23]

On January 17, 1881, Dr. Hunt visited the Almshouse at the invitation of Drs. Branin and McCullough. He inspected the Almshouse drainage and water systems, a normal first step for disease control. His survey did not result in any change in the conditions that prevailed at the institution. On February 3, Drs. Hunt and F. Gauntt of Burlington city, and Professor C. F. Brackett of Princeton, members of the State Board of Health, visited the Almshouse and concluded that the disease was a threat to the entire community. To contain the epidemic, they recommended a system of quarantine and a program of disinfection to be administered by medical personnel. However, by this late date some of the residents had departed hastily from the poorhouse. Camden city declared a quarantine designed to prevent any intercourse with the Almshouse. As a result of the second visit by Dr. Hunt, steps finally were taken to properly cleanse the buildings and residents. Dr. McCullough reported to Hunt that he had personally "organized a scrubbing and whitewash force." McCullough's optimism was well-founded, but not for himself; he died of typhus fever on March 16, 1881.[2,3,6,20,23]

The working people and the needy in Camden were the victims of the triad of sin, poverty, and disease.

Dr. Hunt recognized that the problem was more than a general cleanup and better sewers and water at the Almshouse. He cited an unnamed observer who wrote, "With regard to the disease that has been so fatal, I think that while perhaps it did not originate in the institution, some of the conditions were favorable to its becoming an epidemic. Many of the men, by exposure and improper and scanty living before they came there, were very much enfeebled, and in right condition to take any disease. Most of them are necessarily filthy in their habits. The clothes of most of these men were saturated with filth, and were of themselves disease-breeding. Having no knowledge of sanitary laws, they would shut themselves up in their rooms in the night and thus have them filled with poisoned and poisonous atmosphere."[6]

By April 4, the epidemic had ended. Of the 103 who had contracted the disease, 33 died; a mortality rate of more than 32 percent. Hunt wrote to the Freeholders and told them that the Almshouse had been grossly neglected. There was a general feeling that prevailed, that events in the Almshouse were "a visitation of Providence," that it forewarned the county officials of the dangers that can arise because of their neglect; that it was necessary to conduct a continual program of providing the residents with clean clothes and food, and to see to their sanitary welfare; that no expense should be spared, and that every precaution should be taken.[6]

SMALLPOX IN CAMDEN

Before the events of the Asylum and Almshouse had transpired, another epidemic had occurred in Camden city, an outbreak that was as threatening as the typhus epidemic and which took more lives. In February 1880, a black worker from the Kaighnsville district painted a home in Philadelphia in which smallpox had been reported. He came down with the disease and a volun-

tary quarantine, without legal authority, was placed on his home; however, visitors continued to enter his home and the disease soon spread throughout the Seventh and Eighth Wards.[24] Fear of an epidemic prompted the dispensary physicians to urge the establishment of a hospital to isolate the victims. However, the Sanitary Committee of the Camden City Council argued that fumigation was sufficient to control the outbreak. Finally, on July 26, 1880, a hospital was established on a lot between the Seventh and Eighth Wards, but not before a court battle had ensued between irate residents who did not want the hospital in their district and city officials. However, the hospital was placed on the previous site of a dump, on which cesspool cleaners had discharged the contents of their carts, and in the proximity of an open sewer.[2,17,24]

As long as the smallpox attack was confined mainly to the blacks and poor whites of the Seventh and Eighth Wards, there was little concern shown by the city or county officials. The manager of the dispensary offered to provide free vaccinations if the city donated the vaccine; the offer was rejected. The City Medical Society was unsuccessful in its efforts to meet with the entire Sanitary Committee of the Camden Council to establish a strict quarantine. It took the intercession of Dr. Hunt, at the behest of the City Medical Society, to arrange a meeting on July 28, 1880, between members of the Sanitary Committee and the local physicians. His recommendations that quarantine and vaccination be implemented immediately were ignored by the city officials. Only the spread of the disease beyond the limits of the Seventh and Eight Wards finally made vaccination more acceptable to the bureaucrats. On August 16, 1880, vaccinations were given to approximately 8,000 people.[2,19,24]

On November 11, a closed meeting of the city physicians was held and a reassuring statement was issued that the health of the county was good and that the smallpox no longer was epidemic.[2] However, Dr. James H. Wroth of the Camden County Dispensary reported that there had been numerous unreported deaths due to smallpox, and so informed the State Board of Health.[24] The following week new cases were reported in the northern section of the city. Anxious to lift the spectre associated with the disease, on December 15 the smallpox epidemic officially was declared at an end by the municipal authorities.[2]

Two weeks later there were 8 new cases reported and the epidemic of smallpox had reached Berlin at an alarming rate. By July 1881, the epidemic had ended, but not before 688 cases were reported, of which there were 134 deaths.[2] Hunt called the procrastination of adequately protecting the people of Camden an "evil"; that only judicious action taken at a later date helped to lower the number of deaths.[6]

CONCLUSION

The working people and the needy in Camden were the victims of the triad of sin, poverty, and disease; victims of a system of debasement that created self-doubt and uncertainty, stinking jails, smallpox, asylum cruelty, almshouse neglect, and typhus fever. They were the victims of criminal neglect because they were poor.

A columnist in the *Independent*, believed to be Hunt, later wrote that the smallpox epidemic startled Camden, "This city of contentment;" that no matter their enterprise, their response to this disease was too slow and that the overcrowding and unsanitary condition of the paupers was the cause of the typhus epidemic. Disease was commonplace, poor health for large numbers of people the norm, living conditions precarious and disheartening. Fear of death was of deeper concern to the elite than the care of the "worthy" and "unworthy" poor, so that their first concern was to reduce the threat to their well-being, then they analyzed the costs and chose a course that restricted further dangers for themselves. It was selfish and short-sighted. Hunt, in an evangelistic tirade wrote, "I tell you nay; but except ye repent, ye shall all perish even thus."[25]

REFERENCES

1. Snowden JW: Climatology of southern New Jersey. *First Annual Report of the Bureau of Statistics of Labor and Industries of New Jersey*, 1878.

2. *Camden Daily Post:* May 17, 1879; July 30, 1879; September 23, 1879; October 6, 28, 1879; November 4, 5, 7, 12, 14, 22, 1879; December 10, 24, 1879; January 6, 31, 1880; February 6, 7, 9, 18, 1880; March 5, 17, 29, 1880; April 23, 26, 27, 1880; September 2, 3, 4, 10, 14, 1880; November 11, 12, 20, 23, 1880; December 15, 30, 1880; January 4, 8, 12, 14, 18, 22, 25, 31, 1881; February 4, 15, 16, 23, 1881; April 21, 1881.

3. *West Jersey Press:* November 13, 27, 1878; December 11, 25, 1878; January 4, 8, 15, 1879; February 12, 19, 1879; March 26, 1879; April 9, 16, 30, 1879; May 21, 28, 1879; June 11, 1879; July 2, 23, 1879; August 6, 13, 1879; September 24, 1879; November 7, 1879; December 24, 1879; January 12, 19, 26, 1881; March 2, 1881.

4. *Camden Democrat:* December 28, 1878; January 4, 11, 1879; March 22, 1879; April 5, 1879; June 14, 1879; February 5, 1881; March 19, 1881.

5. Dorwart JM, Mackey PE: *Camden County New Jersey, 1616-1976: A Narrative History.* Camden County, NJ, County Cultural & Heritage Commission, 1976; Prowell GR: *The History of Camden County, New Jersey.* Philadelphia, PA. L.J. Richards & Co., 1886, pp. 421-422, 423, 708; *Ninth Annual Report of the Bureau of Labor & Statistics*, 1886.

6. *Report of the Board of Health of the State of New Jersey:* 1880, pp. 181-183; 1881, pp. 57-65, 317; 1884, pp. 109-135; 1885, 121-129; 1877, pp. 87-101.

7. *Fourth Annual Report of the Bureau of Statistics*, 1881, pp. 192, 266; *Seventh Annual Report of the Bureau of Statistics*, 1884, pp. 237-256; Glassberg E: Work, wages and cost of living: Ethnic differences and the poverty line in Philadelphia, 1880. *Pennsylvania History*, XLVI, 1979; Laurie B, Hershberg T, Alter G: Immigrants and industry: The Philadelphia experience. *J Social His* IX:218-248, 1975.

8. *Philadelphia Times:* January 8, 1881; January 9, 1881; January 13, 1881; January 16, 1881; February 1, 1881; February 6, 1881; February 25, 1881.

9. *First Annual Report of the Bureau of Statistics*, 1878, p. 113; Bishop J: Suggestions for workingmen. *Fourth Annual Report of the Bureau of Statistics*, 1881, p. 111.

10. Hunt EM: Food. *Third Annual Report of the Bureau of Statistics*, 1880, pp. 319-336.

11. *First Annual Report of the State Charities Aid Association of New Jersey to the Legislature of the State of New Jersey.* Morristown, NJ, January 1887.

12. Boyer CS: Public utilities in Camden, NJ. *Annals of Camden No. 2* (Privately printed, 1921), p. 8; and *The Span of a Century: A Chronological History of the City of Camden.* Camden, NJ, Centennial Anniversary Committee of Camden, NJ, 1927, pp. 53, 55.

13. Wroth JH: Camden sewers. *Trans Med Soc NJ, 1881*, p. 234-238.

14. Report of the 1874 Health Commission, pp. 33-34; *Pub-*

lic Opinion, Vol VI, January 5, 1889, p. 259.

15. Snowden JW: Report of the District Committee. *Trans Med Soc NJ, 1881*, pp. 206-207.

16. Hunt EM: The homes of the people. *Report of BHNJ*, pp. 139-154, 1890.

17. Godfrey ELB: The medical profession of Camden County. Report of the celebration of the 50th anniversary of the organization of the Camden District Medical Society, February 11, 1896. *Trans Med Soc NJ*, 1896; Godfrey ELB: *History of the Medical Profession of Camden County, NJ*. Philadelphia, PA, The F.A. Davis Co., 1890.

18. Boyer CS: *The Civil and Political History of Camden County and Camden City*. Privately printed, 1922; Lanning WM: Improvement of the local sanitary service, Board of Health of the State of New Jersey. *Second Annual Conference of State and Local Boards of Health*. Trenton, NJ, MacCrellish & Quigley, State Printers, 1907.

19. Camden County Board of Chosen Freeholders: *Minutes* January 10, 1881, January 31, 1881; May 14, 1879; June 13, 1879; June 14, 1879; October 28, 1880.

20. *Camden County Courier:* January 22, 1881; February 5, 1881; March 19, 1881.

21. *Journal of the 37th Senate of the State of New Jersey, Being the 105th Session of the Legislature*, 1881; pp. 998-1000.

22. Special Meeting of the Board of Chosen Freeholders: *Minutes* July 11, 1879.

23. Branin HE: History of Typhus Fever at Almshouse, January 8, 1881, pp. 218, 225-226, 228-229.

24. Snowden JW: *Report of District Societies*. 1881, pp. 206-207.

25. State Health Boards. *The Independent* July 14, 1881.

On Display: The Science and Art of Healing

A museum is the caretaker of culture, the purveyor of history. A museum captures a moment in time, halting its progress, permitting one to savor the moment, question its significance, and explore its ramifications. A museum exhibition provides contrast and comparison. The viewer disembarks from the 20th century and enters an environment laden with the trappings of another people or a different era. History no longer is relegated to the two-dimensional pages of the record book. History is experienced.



Figure 1—Arrow extractor with two cutting blades made incisions around the wound to facilitate removal of the arrowhead.

This is true for the three statewide exhibits highlighting "300 Years of Medicine in New Jersey." These exhibitions are located at the Cornelius Low House/Middlesex County Museum, Middlesex General-University Hospital, and the University of Medicine and Dentistry-Rutgers Medical School. At these sites, visitors can experience another time—a testament to the heritage of the people who settled New Jersey. Exhibits include a 1906 hospital ward, a 19th century physician's office, a 20th century dental office and laboratory, military medicine showcase, domestic and folk medicine display, public health exposition, showcase of alternative forms of medical care, Medical Society of New Jersey display, and wallhangings and posters of 19th century medical remedies.

The following selection of photographs by Eric Dummett captures the essence of the celebration. Information on exhibit hours and tours is available from the Middlesex County Cultural and Heritage Commission, 1-201-745-4489.

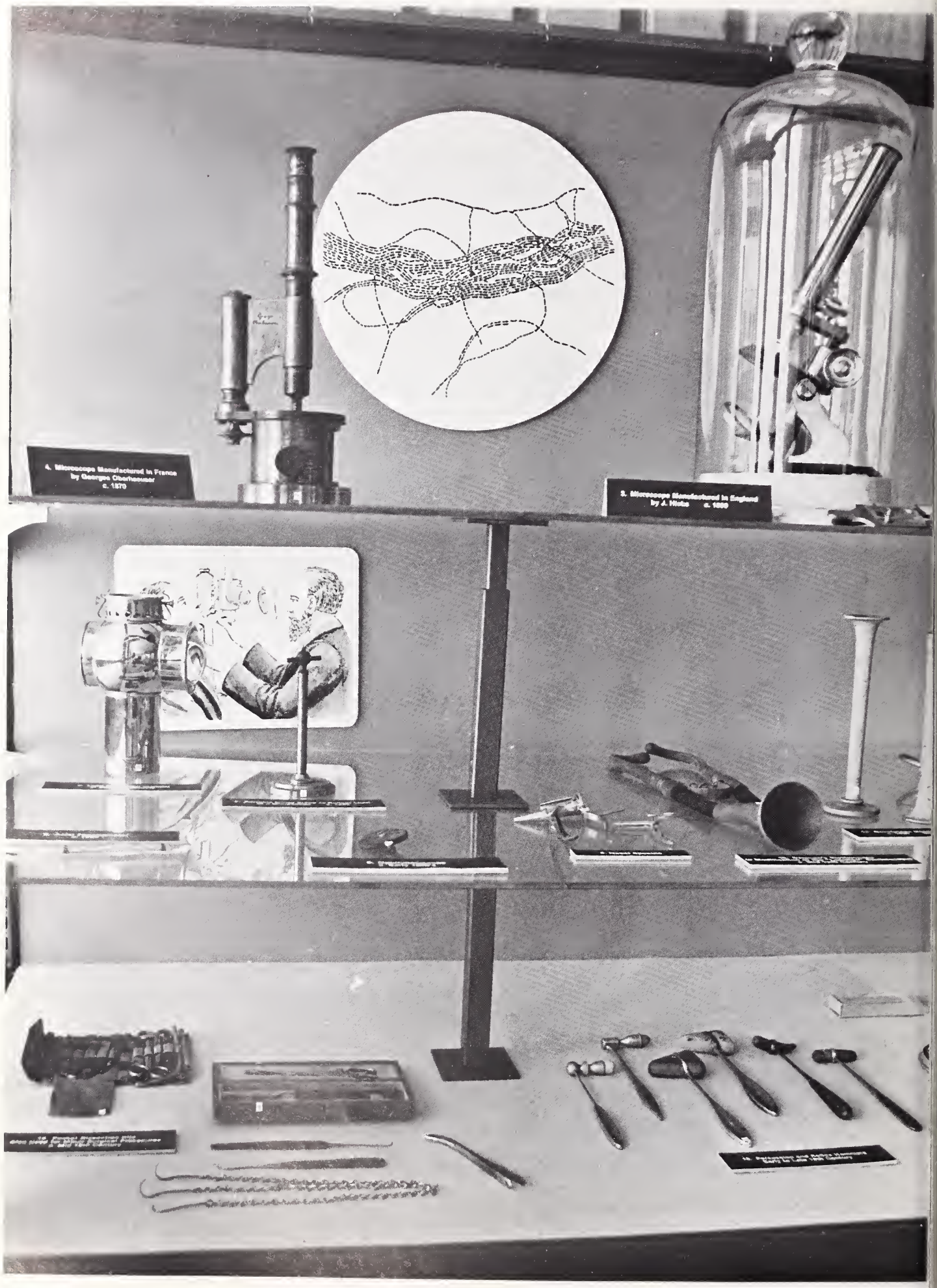


Figure 1—An exhibit case displaying 19th century diagnostic instruments. Exhibit: UMDNJ-Rutgers Medical School, Piscataway



Figure 2—A large drug case and a pocket drug case from the 19th century. Exhibit: UMDNJ-Rutgers Medical School, Piscataway

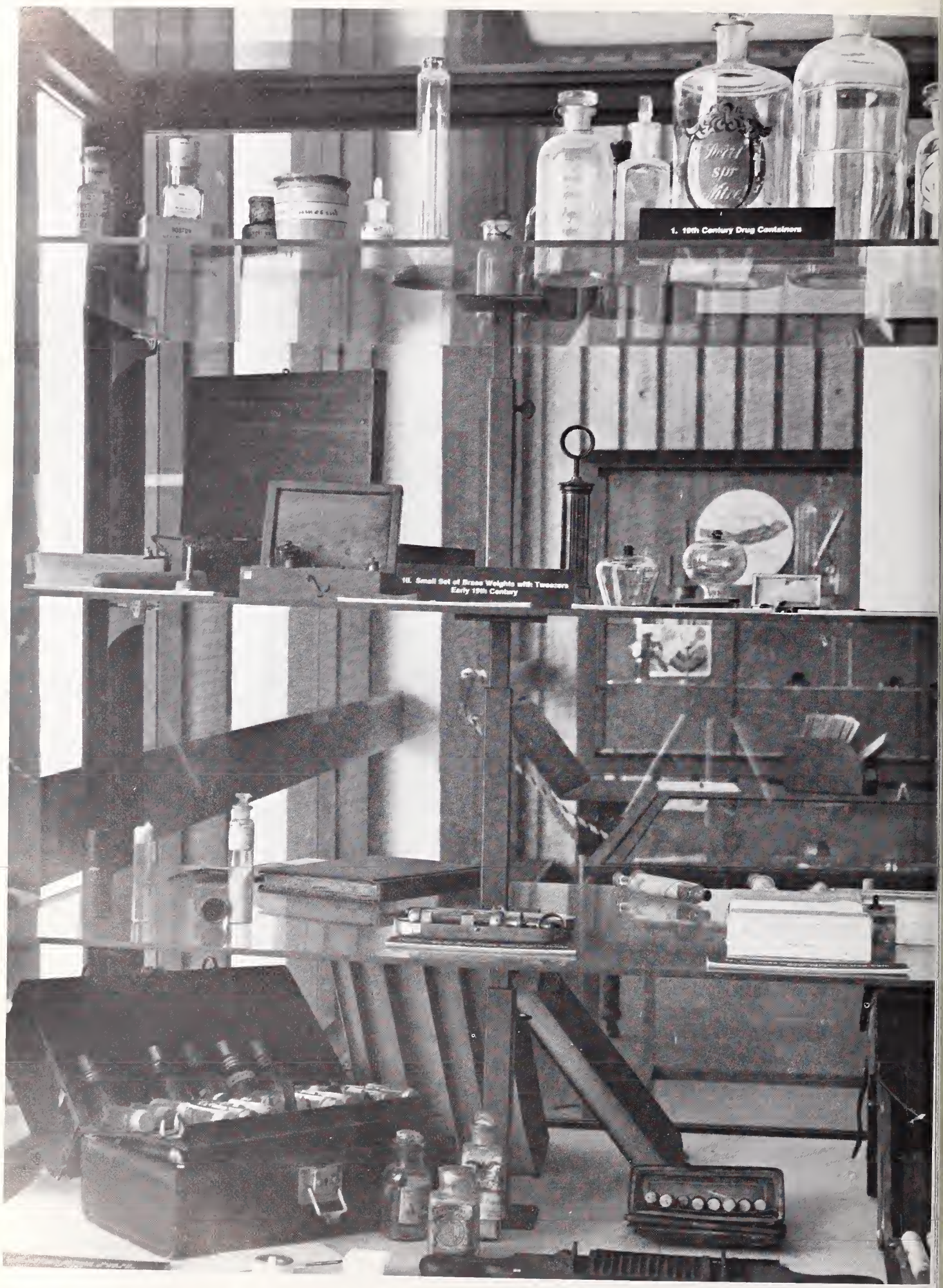


Figure 3—An exhibit case displaying 19th century therapeutics including drugs and a cupping device. Exhibit: UMDNJ-Rutgers Medical School, Piscataway

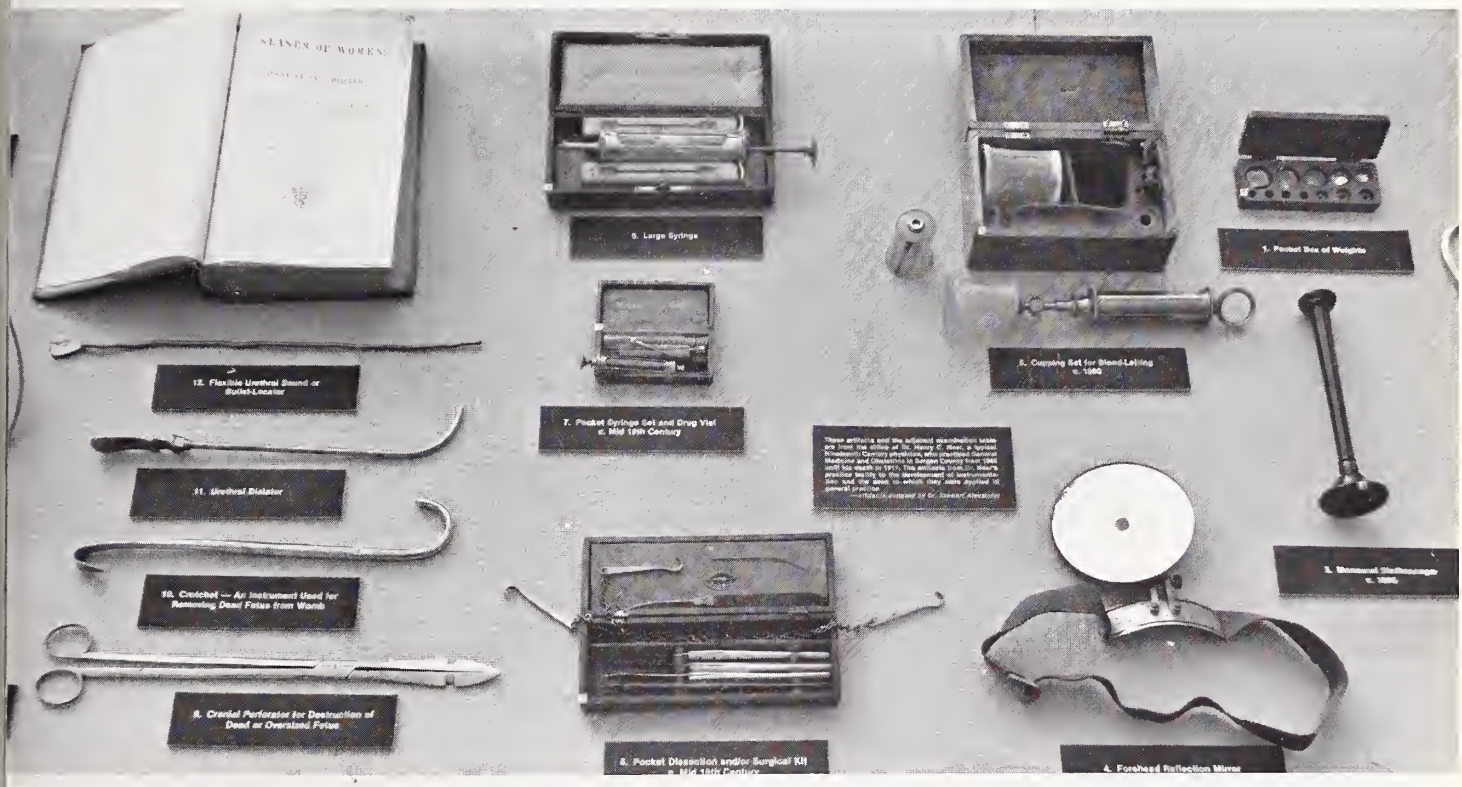
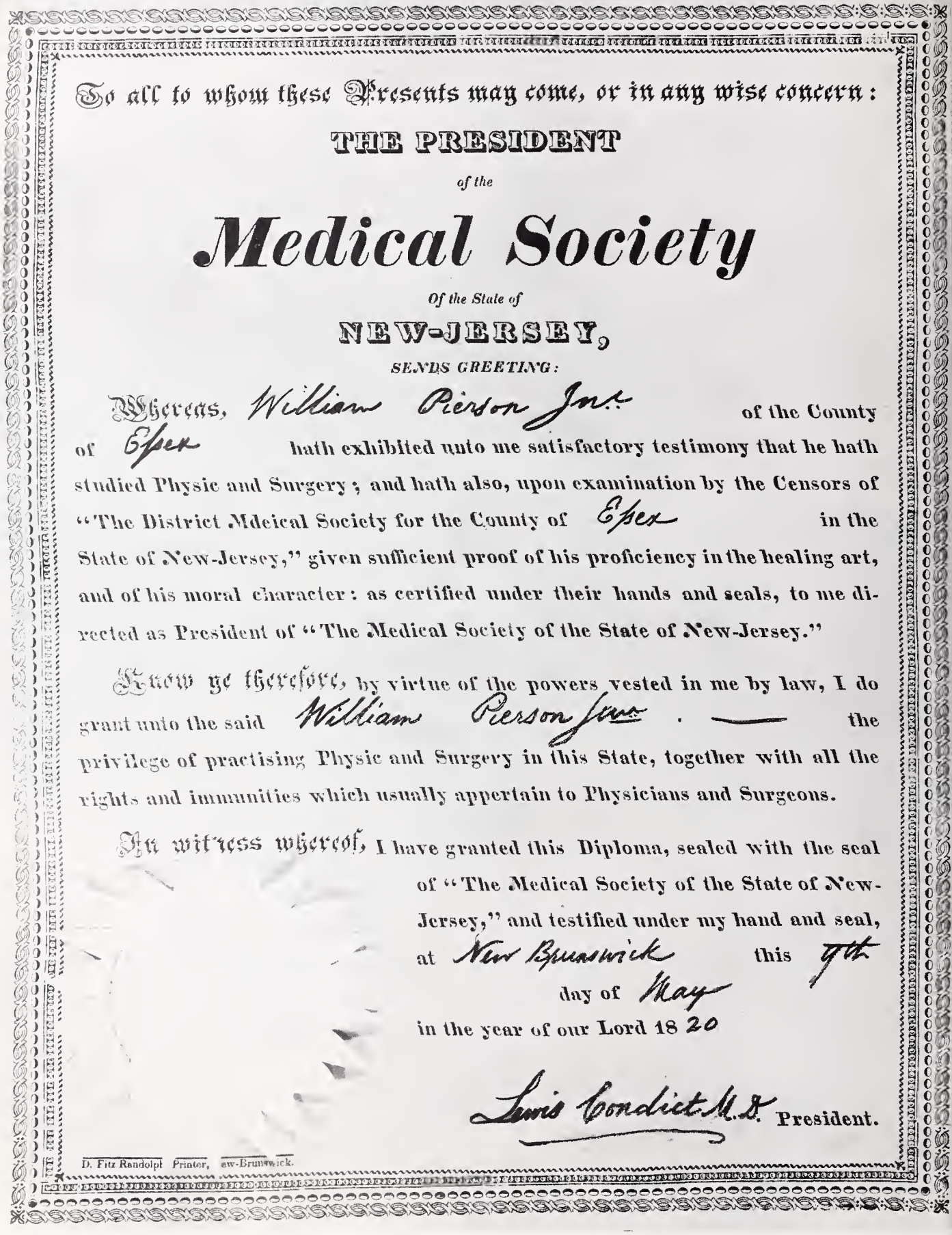


Figure 4—Instruments belonging to Dr. Henry Neer, a typical 19th century general practitioner. Instruments include those used for surgery, obstetrical, and diagnostic procedures. Exhibit: UMDNJ-Rutgers Medical School, Piscataway



To all to whom these Presents may come, or in any wise concern:

THE PRESIDENT

of the

Medical Society

Of the State of

NEW-JERSEY,

SENDS GREETING:

Whereas, William Pierson Jnr. of the County of Esex hath exhibited unto me satisfactory testimony that he hath studied Physic and Surgery; and hath also, upon examination by the Censors of "The District Mdeical Society for the County of Esex in the State of New-Jersey," given sufficient proof of his proficiency in the healing art, and of his moral character: as certified under their hands and seals, to me directed as President of "The Medical Society of the State of New-Jersey."

Know ye therefore, by virtue of the powers vested in me by law, I do grant unto the said William Pierson Jnr. —— the privilege of practising Physic and Surgery in this State, together with all the rights and immunities which usually appertain to Physicians and Surgeons.

In witness whereof, I have granted this Diploma, sealed with the seal of "The Medical Society of the State of New-Jersey," and testified under my hand and seal, at New Brunswick this 9th day of May in the year of our Lord 18 20

Lewis Condict M.D. President.

D. Fitz Randolph Printer, ew-Brunswick.

Figure 5—Diploma, issued by the Medical Society of New Jersey, signed by President Lewis Condict, was presented to William Pierson on May 9, 1820.



Figure 6—Examples of 19th and early 20th century drugs. On loan from Rutgers University College of Pharmacy



Figures 7 and 8—Display case containing surgical instruments. Of special interest on the top shelf (center) are early anesthes containers (1885); top shelf (right) is a Lister carbolic acid sprayer. On bottom shelf (right) is a surgeon's kit from Civil W days. Exhibit: UMDNJ-Rutgers Medical School, Piscataway



Figure 9—Left to right: A spring lancet and case, a 16-blade scarificator, a pair of pocket lancets and case, all used for blood letting; an irrigation syringe and case. Exhibit: UMDNJ-Rutgers Medical School, Piscataway

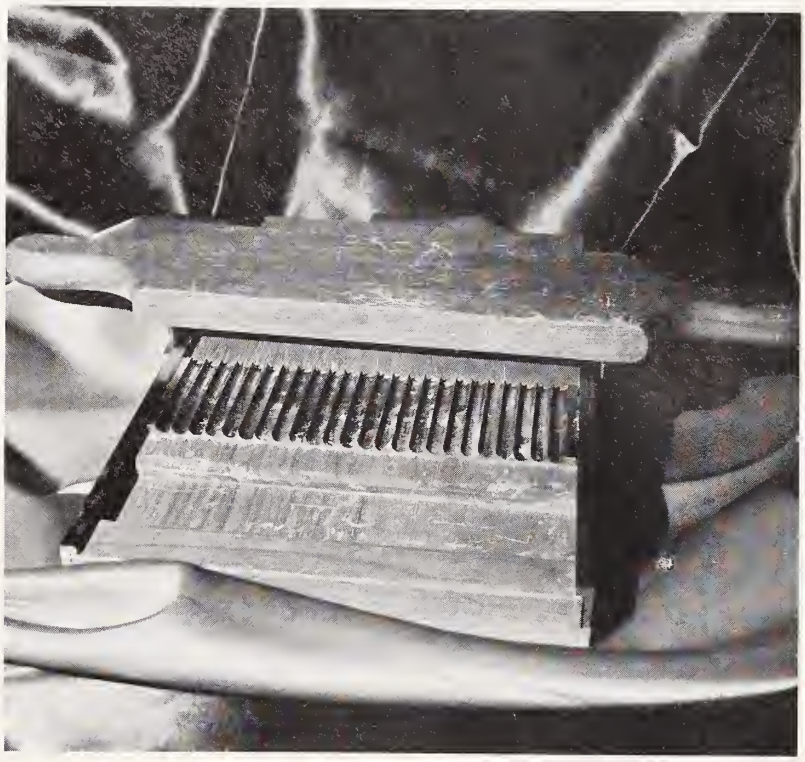


Figure 10—Brass microscope (ca. 1880) Bausch and Lomb with case of interchangeable lenses. Exhibit: UMDNJ-Rutgers Medica School, Piscataway



Figure 11—Trephining set, one of the oldest surgical tools, used to bore holes in the skull. Exhibit: UMDNJ-Rutgers Medica School, Piscataway





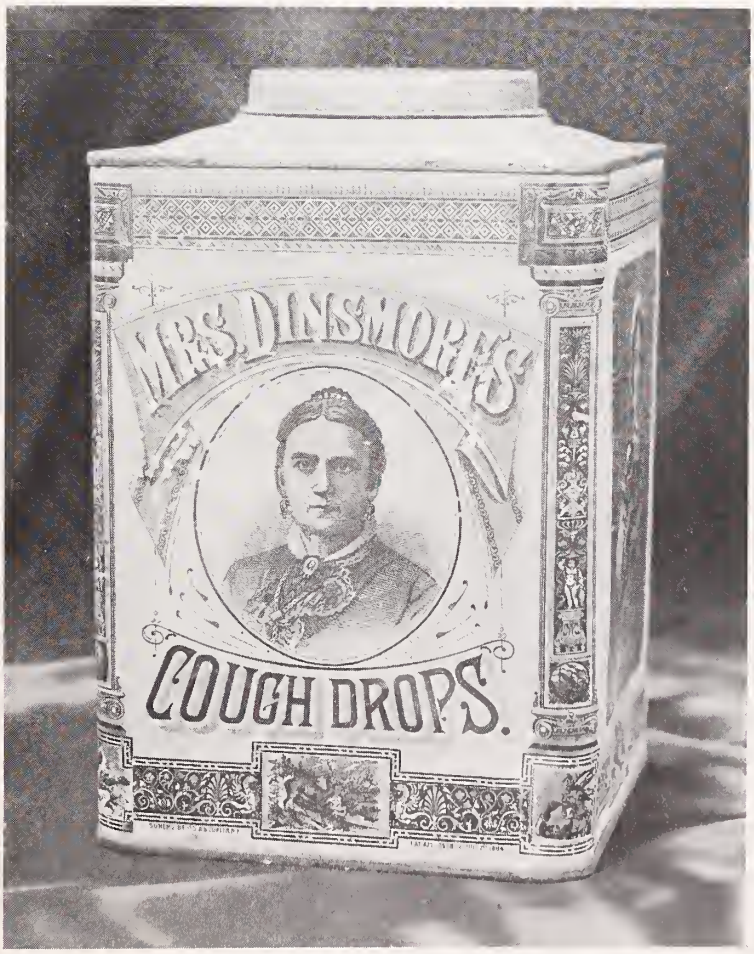
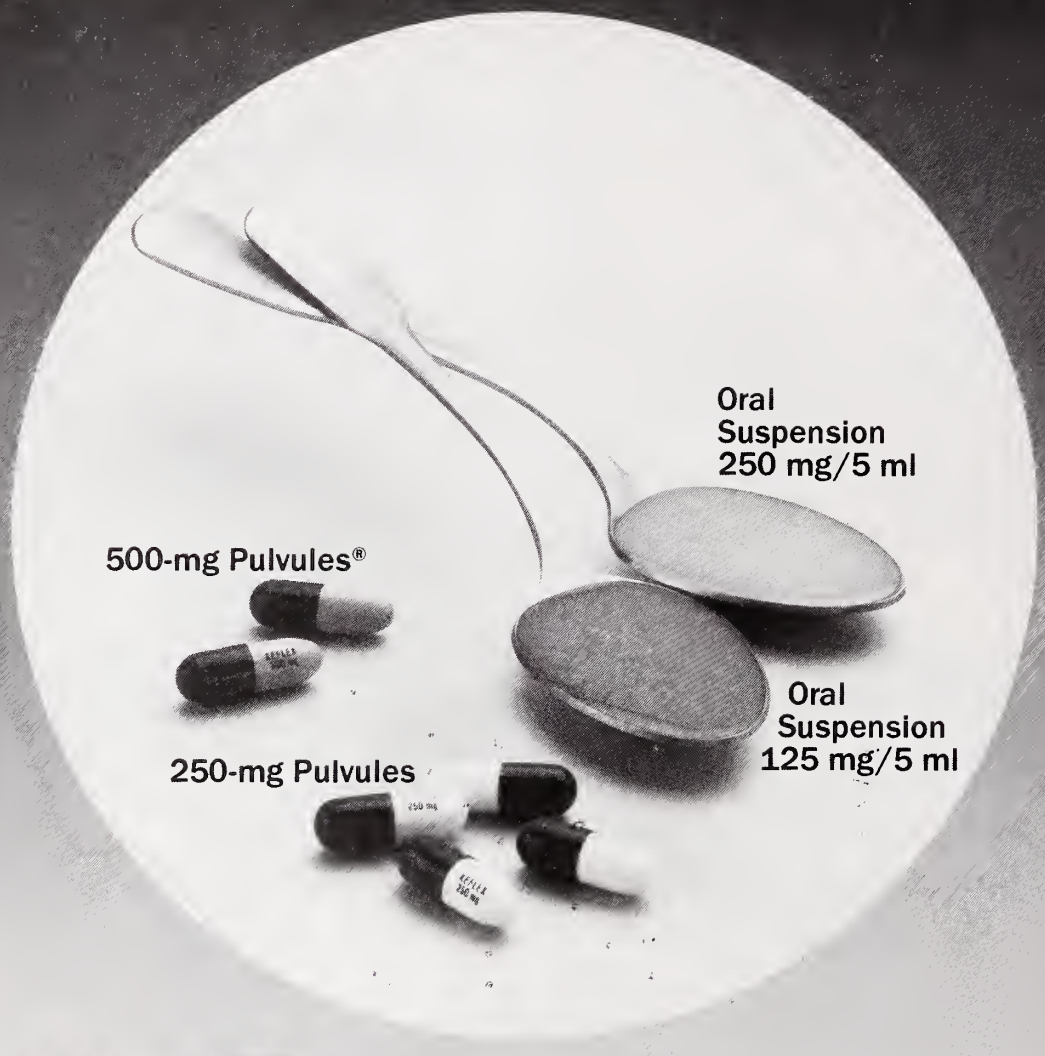


Figure 12—(left bottom) Mrs. Dinmore's tin of cough drops, circa 1880, (left top) a drug scale, (right top) pill roller. Exhibit: UMDNJ-Rutgers Medical School, Piscataway

Easy To Take



Keflex®
cephalexin

Additional information available to the profession on request.

DISTA
420113

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

Samuel Alexander, M.D., and the Uniform Medical Practice Act

Stewart F. Alexander, M.D., Park Ridge*

Samuel Alexander, M.D., was a unique and talented leader of the Medical Society of New Jersey. Best known as the father of the Uniform Medical Practice Act, his life was replete with acts and accomplishments that added a new luster to the practice of medicine in New Jersey.

During periods of great stress and great need, great men have risen from the ranks of the Medical Society of New Jersey to advise, protect, and lead.

The 153rd President of the Medical Society of New Jersey, Samuel Alexander, M.D., was just such a unique and talented leader (Figure 1). Best known as the father of the Uniform Medical Practice Act, his life was replete with acts and accomplishments that made the image of the Medical Society assume new luster. Tracing the path of this physician sheds light and understanding on many of the problems and changes that took place in the second century of the Society.

FAMILY HISTORY

Dr. Alexander's father emigrated to the United States before he was in his teens. Leaving his family near Bratislava, then Austria-Hungary, now Czechoslovakia, he worked and saved to bring his brothers, sisters, and parents, one by one, to this country. He married an attractive emigrant from Bukovena, north of the Carpathian Alps, raised a family of eight children, and rejoiced in the freedom of his new land. Samuel, born February 22, 1888, was the oldest son in this very poor family—poor in the material things, but rich in character, integrity, and drive.

Samuel began working at the age of five, selling newspapers; each penny he earned went to the family for food and clothing. Throughout his life, he worked for everything and exulted in his ability to work. There were no scholarships or student loans, only large measures of self-reliance. Through his growing and developmental years, Samuel studied avidly, stretching for knowledge, yet working a portion of every day. He became known for his ability to read letters received by those who could not read, and to write letters for those who could not write. Samuel kept account books for merchants, arranged accounting systems for some, and job relief for others. Paralleling his work and studies, he developed a great interest in athletics and physical fitness. He ran for exercise almost a century before it became fashionable. Devoted to baseball, Samuel played hardball without gloves and excelled at it. Broken fingers, of which he sustained at least four, did not diminish or quench his love for this sport. In later years, he would steal off to a baseball game whenever possible; he knew all the players, their batting averages, their weak points, and their strong points.

The desire and drive to study medicine had deep roots. Although it seemed impossible at times, by dint of self-study, night schools, and college credits, Samuel was admitted and graduated from the Long Island Hospital College of Medicine in 1910 at the age of 22.

Samuel was accepted for internship at Hackensack Hospital and came under the magical powers of the talented and beloved Dr. David St. John, the founder

*Dr. Stewart F. Alexander is the son of Dr. Samuel Alexander.

of Hackensack Hospital. The young doctor rapidly matured under the guidance of the older physician. It was planned that Samuel would be Dr. St. John's associate when he completed his internship and would continue his training and career in surgery.

Life, however, was to take quite a different and unexpected turn. Dr. Henry C. Neer, who had practiced in Park Ridge for 50 years, became terminally ill with cancer. Dr. Neer was a dear friend of Dr. St. John, and had maintained a large practice and a very current knowledge of the newer developments occurring in medicine. Dr. Neer had developed a very significant medical library, was an innovative practitioner, and was respected far and wide by his peers. He was a pillar of the community. Dr. St. John asked the young doctor to go to this area and serve the people as Dr. Neer had done. And so, Dr. Alexander went to Park Ridge, lived with the Neer family, and assumed the practice. His horse and buggy and winter sleigh soon gave way to an early automobile (Figure 2). The automobile, however, often had to be supplemented by oxen to pull it out of the mud each spring. Dr. Alexander built his house and brought his bride to it, serenaded, as was the custom, by all the townsfolk.

Entering into practice, Dr. Alexander associated himself with the local medical society. The county medical society was the only mechanism for professional exchange and discussion, and Dr. Alexander saw it as an opportunity to initiate continuing medical education. (The county medical society later would sponsor speakers and courses at which the attendance was astonishingly high.)

Dr. Alexander had a very large obstetric practice. Home deliveries were the accepted type of care; realizing their limitations, and lack of reserve support, he established the first maternity home in the area—it was eminently successful. Maternal, prenatal, and postnatal care were placed on high priority; the results were very gratifying.

As his professional skills were honed by experience and self-education, Dr. Alexander reached out into related fields of maternal welfare, public health, public welfare, and public finance. As president of the local Board of Health he was able to monitor and lead in establishing each innovative program in the exploding world of new medical knowledge.

PUBLIC LIFE

It was inevitable that Dr. Alexander's interest in public commitment would lead him into public life. Elected councilman and then mayor, Dr. Alexander's accomplishments were legion: he paved local roads, put in sidewalks, established and equipped a municipal fire department, started a complete local municipal water system, established a municipal owned and operated electric light and power system, and planned for the income of the municipal utility systems to pay the costs of local government.

Dr. Alexander's record of achievement came to the attention of county and state leaders. He was invited to run for the office of county freeholder (county supervisor) in Bergen County; he was elected, and never was defeated in any election. Bergen County benefited in many ways. His self-education in finance permitted



Figure 1—In 1945, as President of the Medical Society of Ne Jersey.

him to set new patterns in county finance and function. Bergen County became known as the most efficient and most economical unit in the state while blazing new chapters in public service. Dr. Alexander organized a method and formula for financial support of the hospitals during the Depression years and saved them from disaster. With great compassion, he devised and put into practice a program of home care for the aged, which emptied the institution previously known as the old-age home. Sensing the diminishing need for tuberculosis hospital beds, Dr. Alexander transformed the county hospital into a general hospital. With the assistance and support of nationally known consultants, he surveyed hospital needs well into the future and initiated the hospital planning programs. Still in the field of his special interest in public welfare, Dr. Alexander established the county medical examiner's system to replace the archaic coroner's office.

PUBLIC FINANCIAL CONCERNS

Dr. Alexander's political stature rose because of his public welfare achievements and a recognition of his unusual grasp and concept of public finance. Operating on the repeated premise that a public office is a public trust, he astonished government leaders by what could be accomplished. During the deepest portion of the Depression when tax revenues were severely

reduced, Dr. Alexander developed a system to pay public employees with interest-bearing script.

Achievements in public finance brought Dr. Alexander to the attention of state leaders and he was a frequent consultant to the state scene: When the George Washington Bridge was nearing completion, the state had no funds to construct or complete Route 4, the only New Jersey exit planned at the time. Dr. Alexander took the position that it was inconceivable that the bridge would be opened without adequate egress. He arranged for the county to secure the funds which were loaned to the state so the first sections of Route 4 could be completed.

Foreseeing the growing importance of the federal government in welfare and health matters, Dr. Alexander spoke out clearly in these fields and was called to testify at congressional and senate hearings. His activities materially influenced legislation in these vital areas. He ardently believed that physicians, with other talented health professionals, should participate in government at all levels, citing that they had the opportunity to make great contributions to the welfare and well-being of the public. Dr. Alexander believed that many were fully qualified to effect leadership and that they should learn the art of transmitting theory into practical legislation and procedure.

A MEDICAL LEADER

Medical leadership was the achievement of which he was most proud, as it was awarded by his peers. From his early days Dr. Alexander recognized the needs of medicine in the exploding technological and social revolutions; he also recognized the increasing health and welfare needs of the people. Locally, Dr. Alexander was on the Board of Health, and, as its president for almost 20 years, guided its formative years in the adoption of progressive public health measures. Dr. Alexander organized a county health unit, and served as its president. While serving the public health sector, he was a staunch supporter of organized medicine and its responsibilities in these fields. Dr. Alexander preached to organized medicine that change was the nature of life and human relationships and that change was inevitable—advising never to be afraid of change and to desist from always being opposed to change. He believed medicine should be in the forefront with leadership guiding change into its most beneficial and most productive pathways. To legislators, Dr. Alexander always cautioned and opposed promises made that could not be fulfilled. Active in the county socitey, he led to its incorporation and served as its president. For years he was a delegate to the Medical Society of New Jersey. He was dismayed at times at the reluctance of the Society to step forwad and confront problems that were developing directly affecting the profession and the public. In a fateful convention in Atlantic City, he rose to state that the old "laissez-faire" attitude was failing, new fresh young blood must be recruited, and vigorous progressive fearless leadership was necessary; he offered a candidate to do this in opposition to the recommendations of the hitherto sacrosanct nominating committee. It was an unheard of action, but it was successful. The vibrant, talented, and productive young Spencer T. Snedecor was elected president and



Figure 2—Dr. Alexander, in 1911, the first year of practice.

inaugurated a new vision to the Medical Society of New Jersey.

UNIFORM MEDICAL PRACTICE ACT

Over the years, Dr. Alexander had been concerned with the vagaries of medical licensure and the public conception of and the public confusion with health care. The license to practice is not a right, but a privilege granted to qualified individuals by the various state legislatures to protect the public. Both Dr. Alexander and the legislature were perplexed and astonished by the nature of limited license, special privilege legislation, and the absence of sound definitions of medical practice. He researched and studied the field, discussed and debated objectives, and developed the concept that eventually was expressed as the Uniform Medical Practice Act. This had several fundamentals: public interest is paramount and must be protected; everyone offering services to the public in the healing arts must have the same or equivalent training; if an individual has the same or equivalent training he or she then may offer services in whatever field he or she is qualified; and a suitable mechanism be established in the Board of Medical Examiners to monitor and effect the rules and regulations.

It took years to develop and prove the concept, and years to convince the multitude of professional health providers that this was a wise and prudent proposal. The legislation had to be drafted line by line and was debated at each step; it then had to be introduced to the legislators and to the legislature, referred to committees, debated, and redebated until it finally was passed by both chambers and signed into law by the governor in 1939.

The Uniform Medical Practice Act produced peace and calm in the field for more than 20 years, and was copied and adopted by many sister states. Unfortunately, in recent years special interest pressures, loss of alertness by responsible groups, and deterioration of the professional image have eroded and damaged some of the practical and protective sections of the law.

Dr. Alexander served on most of the committees of the Medical Society of New Jersey, familiarizing himself with its functions, responsibilities, and prom-

ise. He served several terms as trustee and was elected president in 1945 to serve as its 153rd chief executive. Dr. Alexander was concerned particularly with the returning physician veteran who had to make the sometimes difficult readjustment to civilian practice. Many of the young physician veterans had known only wartime medical service and never had been prepared for private civilian life. Many of the older returning physician veterans had even more profound professional problems. Assistance, guidance, and encouragement were needed. Special committees were established and special provisions were made to meet and to anticipate needs that would develop. Opportunities for refresher courses, opportunities for reorientation, and affording of advanced training in the specialties, financial guidance, and assistance in relocation were encompassed in his programs. The establishment of broad-based civilian practice, the expansion of further training and specialty qualification, and the initiation of a tremendous hospital construction program laid the basis for the delivery of the high quality and high caliber medical practice that characterized the next decades. The principle of assistance and support given young physicians was a hallmark of his life.

Dr. Alexander had a tremendous feeling and empathy for the men and women who gave so much to serve their country in time of war. As a young physician he had taken care of many Civil War veterans and listened as they relived their experiences; they gave him books and records of their units and he became so well versed in the history of the Civil War that visits to the battlefields, later in life, were profound and meaningful. He volunteered for service in the medical department when General Pershing led American forces into Mexico in 1916. In World War I, he immediately volunteered but was rejected because of a nonsymptomatic deviated septum. Not to be daunted, he had the septum operated upon and again presented himself as a volunteer, only to be rejected for similar minor but nonremedial defects. In World War II, he served on the Medical Manpower Board, and it often was his unhappy responsibility to decide who would go and who would remain. Dr. Alexander felt strongly that one could not accept the great freedoms and benefits of our magnificent country without being willing to share in its responsibilities and sacrifices, however great, in its time of need. After his death, in his papers were found repeated letters to the Army, pleading for the opportunity to serve in any capacity, in any grade in any part of the world. The answers always were glowing in praise, but dictated that his present duties and services precluded such action.

CONCLUSION

A devoted father and family man, Dr. Alexander delighted in his son, daughter, and grandchildren. Of great pride to him was his daughter-in-law, Lt. Colonel Bernice Wilbur Alexander, whose interests, talents, and achievements so closely matched his vision of the ideal. Her brilliant war record, her professional achievements, and her social, political, and charitable leadership rewarded him for his love. During his terminal illness, she was a national figure in the campaign of Dwight D. Eisenhower for president. He died on September 3, 1952, before the election, but confident that Dwight D. Eisenhower would be president.

Many of his homilies will remain with us and embellish our lives. Integrity, courage, fairness, and compassion were basic to all his concepts. He said it is not wise for a man to accumulate great material wealth; better is it to accumulate wisdom, understanding, and compassion.

SUPPOSITORY THERAPY
DESIGNED FOR YOUR SPECIALTY.

VAGINAL	RECTAL	URETHRAL
Progesterone	Hydrocortisone	Nitrofurantoin (Plain & with HC)
Boric Acid	Lidocaine	Hydrocortisone
Ampicillin/ Nystatin	Analgesic	Tetracycline
	Emollient	Lidocaine
	Progesterone (including rectal soln's)	SMZ-TMP

All preparations are available in your choice of potency and are prepared in heat stable bases suitable for shipping via United Parcel Service (UPS) with next day delivery within a 300 mile radius.

Contact us for any special requirements that exist in your practice.

BELVIDERE PHARMACY & SURGICAL
1101 South Avenue
Plainfield, New Jersey 07062 (201) 756-6695

TAX SHELTER
Real Estate Limited Partnership

- Manhattan Apartment Building
- $10,000 minimum investment
- Sponsor/General Partner is an experienced property manager and Real Estate Broker in New York City
- Investors will own over 85% of the property

Kafarski Partnership Limited Partnership
Robert J. Kafarski, General Partner
510 West 172nd Street, New York, N.Y. 10032
(212) 795-5271

This advertisement is not an offering. No offering is made except by a prospectus filed with the Bureau of Securities, Department of Law and Public Safety of the State of New Jersey. The Bureau of Securities has not passed on or endorsed the merits of this offering.

WE ARE SPECIALISTS in PUBLIC RELATIONS and MARKETING
FOR THE MEDICAL PROFESSION
for a confidential interview call
(201) 531-7080
phyllis kessel associates
780 West Park Avenue, Oakhurst, NJ 07755

Doctors: Write your own prescription to cure insurance pains . . .

℞ Prescription

Name MSNJ Member

MSNJ Group
Blue Cross/Blue Shield Major Medical and Dental Insurance

that provides:

- **Flexible plans**
- **Comprehensive benefits**
- **Low, competitive rates**
- **Centralized Administration**

Designed and Administered by
DONALD F. SMITH & ASSOCIATES

℞ Prescription

Name _____

Address _____

Phone _____

Please send more information on the MSNJ

☐ Blue Cross/Blue Shield Program
☐ Major Medical Program
☐ Group Dental Program

Return to:
Donald F. Smith & Associates
One Airport Place, Route 206 North
P.O. Box 2197,
Princeton, New Jersey 08540
(609) 924-8700, (201) 622-6046

Note: If you're new to medical practice in N.J. . .

You don't have to buy commercial malpractice insurance

JAMES S. TODD, M.D., *Chairman/Board of Directors, Medical Inter-Insurance Exchange of New Jersey*

AS you made your decision to establish yourself in New Jersey, you no doubt heard horror stories about our professional liability insurance problems. The legal risks we assume in this business have grown so far out of proportion that many commercial underwriters have been simply unable to cope, resulting in abrupt and often untimely suspension of coverage.

As a new practitioner in this State, either relocating or just beginning your professional career, you have an alternative to commercial insurance. The Medical Inter-Insurance Exchange provides an opportunity to build your new practice on the most secure footing possible with long-term peace of mind.

Founded in 1977 at the peak of the "premium crisis," the Exchange is a wholly doctor-owned cooperative organization through which we insure *ourselves* for our own sake. Membership has grown to two-thirc of all practicing physicians and surgeons in th state. Because we're in it for security — *not for profit* — we can provide for ourselves the absolute best available insurance product for the money. Every dollar we take in goes towar protection (no sales commissions) and every dollar left over is returned to us — in cash.

You owe it to yourself to know your options and the practicalities of each. We're here to help you sort them all out. Call and talk directly to our Vice President and Directo of Policyholder Services, Bill Reilly, **TOLL FREE (in N.J.) 800-257-6288** or (609) 896-2404 from other areas. We look forward to hearing from you.

A professional service message from the
Medical Inter-Insurance Exchange of N.J.
Two Princess Road, Lawrenceville NJ 08648
(609) 896-2404



Frederick B. Kilmer: A Notable New Jersey Pharmacist

Roy A. Bowers, Ph.D., New Brunswick*

Frederick B. Kilmer was one of New Jersey's outstanding pharmacists. A dedicated professional, Kilmer worked to advance pharmacy and the role of the pharmacist in the health care field.

The literature abounds with the life and works of Frederick B. Kilmer. *American Druggist* calls him "one of the most fascinating individuals American pharmacy has given to the world."[1] David L. Cowen in his history of the New Jersey Pharmaceutical Association selected F.B. Kilmer as one of two outstanding pharmacists in New Jersey history.[2]

EARLY LIFE AND EDUCATION

Frederick Barnett Kilmer was born on December 11, 1851, in the village of Chapinville, Connecticut, the son of Charles Kilmer, a minister of the gospel, and Mary Langdon Kilmer. His early education was obtained in the public schools of Binghampton, New York, and the Wyoming Seminary, Kingston, Pennsylvania.[3]

Peter A. Soderbergh suggested Fred's academic background to be a very bothersome and bewildering issue, which neither he nor his wife helped to clarify or unravel.[4] For example, after 1900, Kilmer permitted writers and editors to describe him as "Dr." Mrs. Kilmer attributed a "Ds.C." (or, correctly, "D.Sc.") to her husband in her autobiographic writings as a matter of course. This became conventional wisdom in time, and regularly was assumed and perpetuated by writers, editors, and reporters. Another such problem concerns the assertion that Kilmer graduated from the New York College of Pharmacy with a Ph.C. degree in the 1880s. Soderbergh's considered conclusion is that it is likely that Kilmer took courses at the New York College of Pharmacy on and off from 1876. The College offered night courses Monday through Saturday starting in 1878, and Kilmer easily could have commuted from Morristown, and, later, New Brunswick, to East 23rd Street in New York, over a period of years. Yet, Kilmer's name does not appear on the lists of the New York College of Pharmacy graduates for the period of 1870 to 1928.

Kilmer is said to have taken "advanced courses" at Yale, Columbia, and Rutgers in chemistry. The New York College of Pharmacy was incorporated into Columbia University in 1904, and since he lived in New Brunswick, the home of Rutgers, Kilmer could have availed himself of the opportunity of taking courses there. He could have travelled to New Haven, but the official Yale directory of graduates, nongraduates, and honorary degree recipients (1901 to 1932) does not include his name as an enrollee. (In fairness to Kilmer, in his profile in *Who's Who*, he did not mention Yale, but he did allow his entry to say that he graduated from the New York College of Pharmacy.) Furthermore, in his 1901 work, *The Story of Papaw*, Kilmer is described as "Ph.C." and "B.I.Ch.," which clouds the issue even more, since he obviously approved the pamphlet for release and thereby encouraged people to believe that he was a degree-holder. There is no doubt that

*Dr. Bowers is Dean Emeritus, Rutgers College of Pharmacy.

Kilmer was awarded the honorary degree of Master of Pharmacy (Ph.M.) by the Philadelphia College of Pharmacy and Science in 1920.[5]

With this data, we are obliged to conclude that Kilmer held no degrees but the Ph.M. Why he felt he had to allow the world to assume otherwise is an intriguing question. A plausible explanation for this may rest with the state of pharmacy education in the 19th century. Prior to 1900, "drugstore experience"—of which Kilmer had plenty by 1880—was a major requirement for a diploma in most colleges of pharmacy. Therefore, Soderbergh concludes it entirely is conceivable that, in his own way, Kilmer did have the highest level of training in his time—and that, later, as pharmacy education developed, he merely embraced all of the degrees he would have had if he were a 20th century professional.

PROFESSIONAL WORK

When Kilmer came to New Jersey, he settled in Morristown and then opened a pharmacy in New Brunswick at the busy intersection of George and Albany Streets where he remained for over ten years. He sold his pharmacy in 1889 to become director of the Scientific Laboratories of Johnson & Johnson.

Kilmer's relationship with Johnson & Johnson lasted for 45 years; at Johnson & Johnson he had charge of a variety of programs. The "scientific" activities appeared to be mainly developmental: standardization of tests and formulae, development of new processes and techniques, and use of quality control procedures. Some experimentation took place, however, with regard to sterilization of bandages, gauzes, and ligatures. In addition he was responsible for some of the advertising and public relations.[2]

Kilmer contributed immensely to the early progress of the Johnson & Johnson enterprise. In 1901, he put together the *Standard First Aid Manual* that Americans loved so well, and it ran through 11 revisions by 1932. His editorship of Johnson & Johnson's *Red Cross Notes* (1897 to 1928) and *Red Cross Messenger* (1908 to 1930), directed at the medical and pharmacy professions, clearly elevated public awareness several levels above where it had languished before 1900.

Fred Kilmer, the pharmacist, displayed a catholicity of interests, a breadth of intellect, and a capacity for work. He joined the New Jersey Pharmaceutical Association in 1878 and served as vice-president in 1884, and 1885, president in 1886, and secretary in 1887 and 1888. During these years, and long after he stopped practicing pharmacy, he was a regular contributor to the programs of the New Jersey Pharmaceutical Association and by 1920 about 30 of his papers had been published in the *Proceedings*.[2]

KILMER AS A WRITER

Kilmer published 85 articles between January 1897 and December 1933. Appearing in the *American Journal of Pharmacy, Practical Druggist, American Druggist*, and the *Journal of the American Pharmaceutical Association*, they covered pharmacognosy, history of drugs, professionalism in pharmacy, education, commercialism, practical pharmacy, and pharmacopoeial analysis. A large number of articles are brief treatises on a favorite concern: dyspepsia. He also waxed wise on medicinal plasters, surgical dressings, old-time remedies, pharmacopoeial revisions, Saint Hildegarde, and the positive features of the Great Depression. His first published article of any consequence was "Modern Surgical Dressing" in the *American Journal of Pharmacy* (January 1897), a 15-page paper he read in December 1896 at the Philadelphia College of Pharmacy at age 45.

The voluminous file on Kilmer in the American Institute of the History of Pharmacy revealed a steady flow of correspondence over three decades with Edward Kremers, noted University of Wisconsin pharmacy scientist and historian, on Kilmer's scientific investigations, history of pharmacy, drug plants, libraries, and views on the status of the pharmacist and drugstores. The night-shades were among his favorite drug plants. One of Kilmer's last letters written to Kremers on January 19, 1932, epitomized his respect for Kremers: "When I am in search of something, I generally fire an inquiry at you, and you are always very kind in your returns."

Among Kilmer's historical pastimes were arranging exhibits, one of which, near the end of his life in 1933, was displayed in St. Peter's Hospital, New Brunswick. The exhibit included: x-rays depicting a coin in the stomach of a child; pictures showing operations of earlier days, with crude instruments; copies of famous woodcuts in medicine and surgery; and reproductions of the famous paintings of "The Doctor" and "The Country Doctor."[6]

As a perennial optimist on the glorious future of his profession, Kilmer continually reminded pharmacists in his speeches and writings about pharmacy's progress and opportunities for its advancement. Among one of these contributions was "A Message of Cheer" to the Chicago Veteran Druggists Association in 1933. He began by skipping back to the "good old days" when he got his first job in a drugstore by saying: "The very first week he heard the boss tell a man that the drug business was 'going to the dogs.' Business was bad. Profits were shrinking. Incompetent men were coming into the trade. Pharmacy was on the decline. Everything was gloom. I was troubled. I did not want to sail on a sinking ship. My first thought was to quit. Then I concluded to stay the week out and get my two dollars. I stayed on, and have been in the ranks ever since." Harking back to the stories of the trials and tribulations which have surrounded the apothecary, the pharmacist, and the druggist for 40 centuries, he said: "And yet you find a drugstore on every corner, and several in the middle of the block." Then he went on to list the profession's accomplishments with the caveat: "When we come to look things over, do we find it true that in a generation or two which we have spanned, pharmacy—true pharmacy—has made more progress than in all of the 40 centuries recorded in La Wall's book, *Four Thousand Years of Pharmacy*."[7]

Kilmer was a champion of both pharmacy teachers and editors as men of outstanding influence in moulding and guiding of pharmacy. "Hand in hand with journalism stands," he wrote, "the College of Pharmacy in its work of guiding youth to become pharmacists. Interlocking with both are the associations. Each is complementary to the other. The advancement of phar-

macy must come from the united efforts of these agencies."[8] In an era when the few pharmacy graduates in the profession often lacked the respect of drugstore owners, Kilmer repeatedly championed the role of the colleges for the betterment of practitioners. In one of his articles, "What Is Wrong with the College Graduate?" he began by quoting the head of a store employing a goodly number of pharmacists with the oft-heard: "I wouldn't hire graduates in pharmacy, if I could help it." Then he prophesied eloquently that these future pharmacists of America will hereafter control associations, help to shape legislation, make plans for college education, and in the generations to come will control pharmacy."[9]

Fred Kilmer was a pioneer in championing the use of the public media in the enhancement of the role of the pharmacist in health care as one of the proponents of National Pharmacy Week. The idea from which National Pharmacy Week emerged was born at the 1924 annual meeting of the American Pharmaceutical Association.[10] While Robert J. Ruth of Philadelphia is known as the "Father of Pharmacy Week," Ruth himself paid tribute to Kilmer as an early crusader for the cause and acknowledged that Kilmer's efforts were largely instrumental in contributing a marked impetus to the Pharmacy Week movement and its worldwide mission. Because of this interest, Kilmer headed an Advisory Committee in 1925 composed of prominent men in pharmacy from every section of the country which led to its first observance in the same year.

In the following year Kilmer sparked the observance of Pharmacy Week locally in New Jersey through an expansive interview carried in *The Sunday Times*, New Brunswick, on October 10, 1926. He extolled the pharmacist in New Jersey, and farsightedly he spoke of the opportunities for women in the profession: "A modern development has been dubbed 'Pharmacy in Skirts.' It is a fine calling for women and for a great many of them a decided success. For one thing, they have cleaned out the dark corners and brought sunshine, order, and artistry into the old time drugstore. Women patrons are glad to be served by women pharmacists and men don't object."

A further example of Kilmer's devotion to the elevation of pharmacy among the public was a string of slogans with which he is credited. "Your Druggist Is More Than a Merchant" simply illustrated his campaign for the elevation of pharmacy to a professional status. "Try the Drugstore First" and "Ask Your Druggist" indicated that professionalism and proper attention to the front of the store were not incompatible.[2]

Kilmer encouraged pharmacists to pursue the history of pharmacy as a hobby. In his article "History as a Pastime,"[11] he said that the study of history is rightfully within the province of the pharmacist. The philosophic aspects of history should appeal, he continued, to the scientific man, but there are other phases of history that are more inviting as recreation; its pursuit will bring relief and relaxation from the vexations which fill our lives.

FAMILY LIFE

When inquiring into the life of Fred Kilmer, one cannot ignore his family, which had a profound influence on him. Closest to Fred was his wife, Annie Kilburn Kilmer, a gifted speaker, an entertaining writer, and a talented musician. From her pen came many magazine articles and books of rare charm and musical composition for six of her son Joyce's poems. Her home was the meeting place of celebrities in literature, art, and music. Possibly her most poignant feeling toward her husband was expressed in the dedication of her book, *Whimsical Whimsies*, written in 1927 containing a wish which Providence granted:

> Dedication
>
> To one whose counsel was always asked after I had accomplished something, the result of which I was a little dubious, and whose sympathy never failed me. Who, while he may not have always understood, at least fully appreciated me—who has always granted me every wish, and who, I trust, will grant my last, that of allowing me to go before him. These scribblings are dedicated,
>
> My Husband

The first Kilmer home at 17 Codwise Avenue (now Joyce Kilmer Avenue), New Brunswick, in which Joyce Kilmer was born (December 6, 1886) was acquired by the state of New Jersey and dedicated as a memorial to the life of the war hero on July 4, 1930. The most celebrated of his family, Joyce wrote in 1913 the popular poem, "Trees." The poem was put to music by Oscar Rasbach in 1922 and went on to become a staple of popular singer's repertoires. Both the poem and the song still are very popular. The Joyce Kilmer Post No. 25, American Legion, and the Legion Auxiliary now occupy the house. Currently, the second floor in the museum contains memorabilia of Joyce. Until the death of Fred Kilmer, the family home was at 147 College Avenue, New Brunswick, amidst the Rutgers campus, now the site of Stonier Hall, a graduate student dormitory. Fred maintained a large drug garden at his home which frequently was open to the public. It has been said that Fred enjoyed sitting on his back porch overlooking Neilson Athletic Field observing Rutgers Varsity football and other contests. The front of his home faced an open field (now the site of a gymnasium) where the first intercollegiate football game occurred in 1869—Rutgers versus Princeton.[12]

For those who came after the Kilmer family, Joyce assured preservation of the family name among the public and Fred in pharmacy. Among the benefactions in his will were two endowed awards bearing his name.[13] One was for an Annual Award to the author of the best paper submitted to the New Jersey Pharmaceutical Association by a graduate pharmacist. The other is a national award administered by the American Pharmaceutical Association presented annually to an undergraduate or graduate student in a school of pharmacy for the best paper of the student's own work in the field of pharmacognosy. Fred Kilmer left an endowment to the Philadelphia College of Pharmacy and Science (he was a trustee for ten years) to provide for the maintenance of the Kilmer Botanical Garden which was adjacent to the College until October 1968, when it was moved to an experimental greenhouse.

Kilmer's memberships in scientific societies included chemical, pharmaceutical, biological, sanitary, cultural, and historical groups in this country and in

Britain, Germany, and Argentina exemplified his broad interests. He was president of the New Brunswick Board of Health and of the New Jersey Microscopical Society.[2]

CONCLUSION

As a person, Fred Kilmer was firm in his convictions, taciturn, conservative, preoccupied, undemonstrative, and obsessed with his work. He was 5'8" of medium build, blue-eyed, and blonde—then grey-haired. He was a smoker of cigars and a pipe, a teetotaler, an avid reader in his field, and very careless about his appearance in his twilight years. He married on Christmas Day, 1871, at age 20, and outlived his wife and his four children—two of whom died in infancy, and one of whom took his own life, and the youngest, Joyce, the soldier-poet, who was killed in action in France on July 30, 1918. He bore more than his share of grief. Kilmer died on December 28, 1934. Kilmer's reputation for parsimony is belied by the contents of his will, through which he gave in excess of $10,000 to churches, hospitals, and professional groups.

Fred Kilmer was eccentric, sometimes ahead and sometimes behind the times, and often misunderstood—but he was his own man. Fred Kilmer lies among members of his family in Elmwood Cemetary in New Brunswick. On his stone it says: "I have fought a good fight, I have finished my course, I have kept the faith." And so he did.[13]

REFERENCES

1. *American Druggist*, May 5, 1958, p. 90.
2. Cowen DL: *The New Jersey Pharmaceutical Association 1870-1970*. 1970.
3. *Am J Pharm*: 1935, p. 84.
4. Letter to R.A. Bowers, December 27, 1983.
5. *Bulletin of Philadelphia College of Pharmacy and Science*, June 1920, p. 4.
6. *The Practical Druggist*, November 1933, p. 38.
7. *The Practical Druggist*, May 1933, p. 9.
8. *The Druggist Circular*, June 1927, p. 3.
9. *J Am Pharm Assoc* 18:4, 1929.
10. Ruth RJ: The history of national pharmacy week. *J Am Pharm Assoc* 20:696-706, 1931.
11. *The Practical Druggist*, January 1924, p. 20.
12. McCormick RP: *Rutgers: A Bicentennial History*. New Brunswick, NJ, Rutgers University Press, 1966.
13. *J Am Pharm Assoc* 24:3, 1935.

William Augustus Newell, M.D., and The Life Saving Service

Peter J. Guthorn, M.D., Brielle*

Dr. William A. Newell, a Monmouth County physician, made his greatest contribution as father of the Life Saving Service. This Service aided passengers and crews of wrecked vessels on the coast between Sandy Hook and Little Egg Harbor or the adjacent Long Island shore.

William Augustus Newell (1817 to 1901), a Monmouth County physician and political figure, made his greatest contribution as father of the Life Saving Service.

William Augustus descended from New Jersey families, but was born in Franklin, Ohio, where his father was temporarily employed as a civil engineer. He returned to Monmouth County with his parents, where he attended a classical school at Perrineville which had been opened by the Rev. William Woodhull soon after he took charge of the Presbyterian Church in 1826. The family moved to New Brunswick, where Newell attended schools, and graduated from Rutgers College in 1836.

As part of a family tradition, William Augustus elected to study medicine. He began with Dr. VanDuser of New Brunswick, whose daughter Johanna he eventually married. He later enrolled in the University of Pennsylvania, graduating with a medical degree in 1839. Two of Newell's young brothers, William Dunham and Azariah D., studied medicine and practiced in Monmouth County.

William Augustus began practice with his uncle, Dr. Hankinson, at Manahawkin. The small community was on the main road north and south through the sparsely populated pine region, closely tied to the coast and Barnegat Bay, and its activities. The local industries were fishing, lumbering, the production of charcoal, subsistence farming, a diminishing bog iron production, and development of early resort activities. Here he became acquainted with the sea and the loss of life following winter shipwrecks. William Augustus was appalled when 13 bodies came ashore at one time and later reported that in 1846, 55 bodies had been thrown on the beach at one time.

WRECKS, WRECKING, AND LIFE SAVING

A tradition of relief, aid, and assistance to shipwrecked sailors had been established in England, and in New England by the Massachusetts Humane Society in 1786. The Humane Society established houses of refuge along the exposed and unprotected portions of the New England coast. These provided shelter from the weather, food, and necessary supplies for survival for those fortunate enough to have reached land. The Society began to place lifeboats on the most perilous parts of the coast about 1807. The first was at Cohasset, close to the southern extremity of Boston Harbor, an area of great potential danger.

The importance of wrecks and "wrecking," the salvage of ships and cargoes, and, by extension, the saving of lives, was recognized in colonial New Jersey. Certain parliamentary acts for the preservation of ships and goods forced on shore or stranded were to

*Dr. Guthorn was the first president of the Medical History Society of New Jersey.

be read publicly in the counties of Monmouth, Burlington, Gloucester, Salem, Cumberland, and Cape May at four succeeding courts of General Quarter Sessions. Passed June 28, 1766, they decreed the death penalty for those willfully attempting to burn or destroy a ship. Other legislation in 1825, and later years, was concerned with the organization and local administration of wreck management and salvage.

The shore area was divided into districts, each under a "wreckmaster." These were local residents of substance and good reputation, commonly retired shipmasters or surfmen, who were responsible for saving wrecked passengers and crew, and for retrieving salvageable cargo, gear, and rigging. They were appointed for terms by the courts, and were under bond. Occasionally, an intact stranded vessel could be salvaged; but that rarely occurred before the advent of iron or steel hulls.

A distinctive type of small boat was developed along the shore for wrecking and life saving. Their model was that of the smaller beach skiffs used for fishing. The "surf boat" and beach skiff were designed for launching through the surf, to survive off shore, and to land through the surf. Both were constructed by the same boat builders and manned by the same surfmen or fishermen, depending upon the needs of the moment.

The boats were constructed of light lap strake cedar planking over steam-bent white oak frames. The boats had a lively sheer, an essentially semicircular midsection, and a sharply raked, "U"-shaped transom. They were buoyant, light in weight, and handy. The fishing version was about 15 feet in length and 5 feet in beam, launched and rowed or sailed by two men. The surf boat version was about 25 feet in length and comparatively narrower in beam, 6 to 7 feet. It was rowed by four or five oarsmen and steered by the captain in the stern, using another long oar. Great care was taken in the construction of the boats and selection of the crew, particularly the captain (Figure 1).

The operation of surf boats often was a joint enterprise. An "Article of Agreement of a Surf Boat," dated April 13, 1835, is preserved in the Monmouth County Historical Association. The owners, John S. Forman, Morris Freeman, John Morris, and William Akins, agreed to build and own a large surf boat for the purpose of working at wrecks. The document notes that in addition to sharing the ownership, they are "to agree in the selecting of the man to go in the stern of said boat or be captain." Forman was a Manasquan lawyer; Freeman, a boat builder; and Akins, a retired shipmaster and surfman.

Some additional light is shed in an 1846 report by a legislative commission. Three legislators, Peter Vredenburgh, John S. Darcy, and Jonathan C. TenEyck, were appointed by the governor to investigate charges against inhabitants of the coast of Monmouth County, at the time extending from Sandy Hook to Little Egg Harbor Inlet. The charges, refusal to give relief to perishing passengers and crewmen, plundering the dead, and extracting money for the delivery of bodies, arose following the wreck of the ship, the *John Minturn*. The charges were made by members of the crew to the American Shipwreck Society of New York. They were taken up by the press, particularly in New York, and magnified to include wholesale charges of land piracy and even murder.



Figure 1—An artist's rendering of surf boat launching. An 1887 chromolithograph by Frederic S. Cozzens (1846 to 1928). A technically correct study of the boat and crew launching through the surf to render aid to the crew of a stranded vessel, dimly seen at the left, off shore.

The report consists of the sworn (in the case of the Quakers, affirmed) depositions of local inhabitants, the coroner's memorandum book, and correspondence. It disproves the serious charges and indicates the guilt of some of the crew of the *Minturn*. It gives much valuable data, including the use of the term "surf boat," and imparts a great aura of respect for the words and judgments of the wreckmasters and surfmen. The general impression of the statements of the 40-odd deponents in the report is that of personal hardihood, and an ability to come to terms with the hostile environment and its effect.

PRACTICE AND FIRST POLITICAL LIFE

Dr. Newell established his own practice in Imlaystown in 1841, and won his first political office, that of township collector. He was re-elected many times until he moved the short distance to the larger Allentown, a center of activity and transportation in western Monmouth County. Here his practice prospered in the busy community. Well known and popular, Dr. Newell declined a nomination to fill an unexpired term in Congress in 1845, but was elected in 1846; and re-elected by an increased majority in 1848. Abraham Lincoln, a member of the same Congress, occupied an adjoining seat in the House. They boarded and roomed together, becoming close friends.

NEWELL AND THE LIFE SAVING SERVICE

In an address to the Congress in 1848, Dr. Newell reported that the New Jersey coast between Sandy Hook and Little Egg Harbor was more famous for shipwrecks than any other part of the country, including the Florida Reef, as the Keys then were known. In a little more than nine years preceding July 31, 1848, 158 vessels had been wrecked on the New Jersey coast including ships, brigs, schooners, sloops, and pilot boats; and 180 vessels had been wrecked on the adjacent Long Island coast. These statistics had been gathered by Dr. Newell from some of his constituents, some of whom had been deponents in the 1846 legislative report. The adjacent New Jersey and Long Island



Figure 2—Among the wreckers of the New Jersey Coast, this woodcut illustration was drawn by Granville Perkins (1830 to 1895), from *Harper's Weekly* of January 25, 1868. A spirited conjectural series of views of the activities of the wreckers in rescuing stricken passengers and crew members. Pictured are a "Government Wrecking House," wreckers' hut, the recovery of cases of flotsam containing bottles of joyful wreckers, recovery of the drowned, and finally, "the strangers' grave."

shores were the sides of a hazardous funnel directed to the entrance of New York Harbor, at peril in great storms and in decreased visibility, in the days before steam replaced sail. There was no national agency or regular register of shipwrecks or marine disasters or organized service of rescue.

Dr. Newell pointed out that the shore was made especially dangerous by sand bars from 300 to 800 yards offshore, which could be covered by relatively few feet of water. A stranded vessel's crew and passengers were separated from the safety of the shore by an impassable surf, while the vessel was breaking up beneath them. The ordinary ship's longboat was not able to pass over the bar, or negotiate the surf while a surf boat could, and would survive in a sea, and come to shore when the other would be swamped or stove.

The important part of the address was an amendment to the Light House Bill for $10,000 to provide surf boats, rockets, carronades, and other necessary apparatus for the better protection of life and property from shipwrecks on the coast of New Jersey, between Sandy Hook and Little Egg Harbor. The amendment was adapted unanimously, and established the Life Saving Service (Figure 2).

LATER PRACTICE, POLITICS, AND GOVERNORSHIP

Dr. Newell was an earnest opponent to the extension of human slavery during his two terms in Congress from 1847 to 1851. He resumed practice in Allentown, continuing an interest in politics, local fraternal organizations, farming, and the Presbyterian Church.

Nominated for governor in 1856 by a convention of representatives of the new Republican party, and the American party, a residual of the old Whig party, Dr. Newell was elected, and served two terms from 1857 to 1861. President Lincoln appointed him superintendent of the Life Saving Service in New Jersey in 1861, and he served until 1864.

Dr. Newell received the Republican nomination for Congress a third time in 1864, was elected, and aided



Figure 3—An 1880 (circa) photo of Life Saving Station Number 5 at Green's Pond near Long Branch, now named Lake Takanasee. The station was long associated with the Captains Green, who served as wreckmasters, formed volunteer crews, and were captains of later life-saving crews. The surf boat pictured, *Ella Green*, probably was built by William Seaman at Branchport. Other equipment pictured includes a life car in the foreground, invented by Captain Douglas Ottinger of the Revenue Service, and later claimed by Joseph Francis. It was used as a rescue vehicle in place of the breeches buoy in high surf. Also shown are the Lyle gun, projectiles, storm lamp, line sulky, and other necessary gear. The captain and six oarsmen in the foreground are wearing cork buoyed life jackets. Two reserves are on lookout. The original building still is standing.

further in the development of the Life Saving Service (Figure 3). His old friendship with President Lincoln was renewed, and he served as attending physician at the White House.

Dr. Newell ran unsuccessfully for Congress in 1866 and 1870. A factor was the ascendancy of the Democratic party, and hostility of many disappointed Republican applicants for office who were critical of his honest dispensing of party patronage in the past. The same factors defeated his 1877 candidacy of governor.

He resumed practice in Allentown in 1867, until appointed governor of the Washington Territory by President Hayes in 1880. He also was appointed Indian inspector in the same territory, practiced medicine for a year in Olympia, and was resident surgeon in a veterans' home there.

FINAL YEARS AND A PERSPECTIVE

Advancing years and the death of his wife prompted Dr. Newell's return to Allentown in 1899. He resumed practice in response to local demand and personal popularity. As an elder and respected statesman, he was invited to address the Monmouth County Historical Association in 1899, and again the following year on the topic of the Life Saving Service.

Among his interests was the improvement of agriculture. Dr. Newell was president of the New Jersey State Board of Agriculture in 1875, and his efforts were important in support of a federal bureau of agriculture.

Political activities and personality, and many social activities led to membership and office in many organizations. He was vice-president of the National Union League for many years. (The Union League had formed in the North after disastrous Union Army defeats during the early years of the Civil War. Clubs in

many cities distributed war literature, recruited white and black volunteers for the army, and raised money for soldier's relief. Union League clubs in Chicago, Philadelphia, and New York trace their origin to this movement.)

Dr. Newell was also a Freemason, and member of the Odd Fellows, and a trustee of Rutgers College. Two of his seemingly minor activities had other far-reaching effects. He was a delegate to the Republican convention in Chicago in 1860 which nominated Abraham Lincoln. He was later foreman of the Monmouth County Grand Jury which prevented the reopening of the Long Branch gaming and gambling houses and of the race track.

William Augustus Newell continued to remain active until his death in Allentown on August 6, 1901, survived by his three children. He was eulogized by a large number of previous supporters and opponents; and buried with honors in the Allentown Presbyterian churchyard.

REFERENCES

1. Allinson S: Acts Of the General Assembly of the Provinc Of New Jersey. Burlington, NJ, 1776.
2. Elmer LQC: *A Digest of the Law of New Jersey, Fourt. Ed.* Newark, NJ, 1868.
3. Gordon TF: *A Gazetteer Of The State of New Jerse* Trenton, NJ, 1834.
4. Guthorn PJ: *The Sea Bright Skiff and Other Jerse Shore Boats.* New Brunswick, NJ, 1971.
5. Nelson W: *The New Jersey Coast In Three Centuries* New York, NY, 1902.
6. Newell WA: Remarks to the Monmouth County Historica Association, 1899.
7. Newell WA: Remarks to the Monmouth County Historica Association on the Life Saving Service, 1900.
8. Report of the Commissioners To Investigate the Charge Concerning the Wrecks on the Monmouth Coast, com municated to the Assembly, March 20, 1846, Trenton, NJ 1846.

Women Physicians of New Jersey: The Early Era

Christine E. Haycock, M.D., Newark*

Representative women physicians have been selected to try to symbolize the roles of women in the medical history of New Jersey. These outstanding doctors have added tremendously to the health care of New Jersey.

At the turn of the century, there were about 300 women doctors in New Jersey.[1] In 1950, there were 425 women physicians; in 1960, 669; in 1973, 1,052; and in 1983, over 2,000. In 1905, 4.1 percent of all medical students were women; in 1910, 2.6 percent; in 1950, 5.9 percent; in 1961, 5.8 percent; in 1965, 7.3 percent; and in 1975, 20.4 percent. The current percentage is about 32.[4-6]

Statistics indicate that there were 19 medical colleges for women between 1850 and 1895. This number dropped to 8 by 1900 and to 2 by 1910 (in New York City and in Philadelphia) as women began to be accepted in many formerly all-male schools.[2] The famous Flexner report published in 1910 was supportive of coeducational medical schools and probably aided this metamorphosis.[3]

In general, women were more apt to be found in family practice, pediatrics, and psychiatry. In the early 1960s, women physicians in surgical specialties represented less than 2 percent of all physicians. Although women had practiced surgery in New Jersey, it was not until 1961 that Dr. Anita Falla and the author became the first board certified general surgical specialists in the state.

The American Medical Association (AMA) did not accept women as members until 1915, and even then the opportunity to have a paper accepted for presentation was nearly zero. As a result, a number of women's medical associations formed around the country and a medical women's journal was founded. This resulted in the American Medical Women's Association (AMWA) organized by Bertha Van Hoosen of Chicago, coming into existence that same year as a national organization.[7]

New Jersey medical women did not form their own organization until June 1924. Dr. Clara De Hart Krans, of Plainfield, conceived the idea of "promoting friendship" among women physicians and so the New Jersey Medical Women's Association (NJMWA) was born; in 1927, it became a branch of the AMWA.[8] Many prominent New Jersey women physicians have been members of the NJMWA and honored as "Woman of the Year." The group acts to secure positions for physicians and help the American Women's Hospital Association in its overseas work. The group also was active in seeking passage of the HR 826 Bill in Congress in 1943 sponsored by Congressman Emanuel Celler of New Jersey which allowed qualified women to receive commissions in the Armed Forces. Shortly after its passage, four New Jersey women physicians were commissioned and served in World War II. Later, New Jersey women served overseas in the Korean and Vietnam Wars.[9]

It would be impossible to present a study of every

*Dr. Haycock is Associate Professor of Surgery, UMDNJ-New Jersey Medical School, Newark.

early woman physician. Representative women have been chosen to try to symbolize their roles in the medical history of New Jersey from 1834 to the 1960s.

Sophia Presley, M.D. Born in Ireland in 1834, Dr. Presley came to the United States as a child. She studied premed at Granville Female Seminary, Ohio, and attended Women's Medical College of Pennsylvania, graduating in 1876. Since no other hospital would accept her, Dr. Presley interned at the Women's Hospital of Philadelphia and remained there an additional three years as an instructor in surgery. Dr. Presley then set up a general practice in Camden in 1881 while remaining a clinical instructor at the Women's Medical School. For seven years she struggled to gain membership in the Camden County Medical Society, finally succeeding in 1896. During her early years of practice she was forced to move at least nine times from one office apartment to another until 1907 because "reputable ladies ostracized the early medical women of America, and landlords refused to rent them apartments for offices." According to her biographer, Cleora Teffean, Dr. Presley had a large practice at her death in 1909 at age 75 as recorded in the *Journal of the Camden County Medical Society.*[10] She was accredited with "earnest zeal and ability" in gaining patient confidence especially of many prominent families. Dr. Presley authored a number of papers on various topics: acquired syphilis, rectal polyps, and puerperal fever. In 1894 to 1895 she was elected secretary of the Camden County Medical Society. In 1894, she headed the gynecological department of the Camden City Dispensary.

Mary E. Gaston, M.D. Born in Somerville in 1856, Dr. Gaston attended Vassar College and graduated from the Women's Medical College in 1883. She obtained an internship in Boston and returned to Somerville in 1884 to begin a general practice. Her obituary noted that she used a horse and buggy to make rounds in the early days of her practice but gave that up in favor of walking. Her father gave her a gun to carry to protect herself, but Dr. Gaston said she was more afraid of the gun than of any harm that might come to her and left the weapon home after a few days. Dr. Gaston retired from practice in 1908 and then devoted her time to establishing the Somerville Civic League, a Red Cross Chapter, the Somerset County Health and Tuberculosis Association, and Somerset Hospital. She died at 100 years of age in 1956.

Alicia H. Ward, M.D., and **Emma Edward, M.D.** The sisters were born around 1855. Data available do not indicate their medical school, but they practiced in Newark in an office which now is the site of the Newark Public Library. Dr. Ward continued to practice until 1922, her sister having passed away several years earlier. She died in 1935.

Florence Voorhees, M.D. Born around 1870 in Woodbridge, Dr. Voorhees graduated from the Women's Homeopathic Medical College in New York and then studied in Europe as did many women to become specialists. After returning from Europe she opened an office in Newark with Dr. Mary Broadnax and practiced obstetrics and gynecology; she was on the staffs of Presbyterian, Saint Barnabas, and East Orange General Hospitals.

Ellen Potter, M.D. One of the most prominent early women physicians in New Jersey, Dr. Potter was born in 1871 in New London, Connecticut. She obtained her medical degree from Women's Medical College in 1903 at the age of 32. Dr. Potter went to New York City to study art; but while living in a settlement house she noticed the need for medical care for the poor and decided to make medicine her career. After graduation she entered general practice for 15 years. She became medical director of Women's Hospital from 1918 to 1920. In 1921, she helped found the Bureau of Children of the Pennsylvania Welfare Department and headed that agency until 1923. Then she became secretary of welfare in Pennsylvania until 1927, the first woman to hold a state cabinet post. Dr. Potter joined the staff of the New Jersey Department of Institutions and Agencies and served successively as organizer and director of the medical department of North Jersey Training School for Feeble-Minded Females, Totowa, and then superintendent of Clinton Reformatory for Women and the State Home for Girls, Trenton. In 1930, she became director of medicine in the department until 1946 when she was promoted to deputy commissioner in charge of welfare and assistance. In the depression of 1933, Dr. Potter worked for the Federal Relief Administration, directing the care of transient unemployed throughout the country. During World War II, she chaired the child welfare committee of the State Office of Civilian Defense. In 1941, she became president of Women's Medical College serving until 1943 while still with the New Jersey Department of Institutions and Agencies. One of Dr. Potter's main accomplishments was in the formulation by the state of regulations governing adoptions in 1946. She fought to prevent a "black market" in babies and provided protection for both the natural parents and the adoptive parents. After her retirement in 1952, she continued to do volunteer work for various state agencies and commissions. She served as national president of the American Medical Women's Association in 1929 and was honored as the "Woman of the Year" by the New Jersey Medical Women's Association in 1954. Dr. Potter was beloved by her colleagues and friends for her calm demeanor and friendly laugh. She enjoyed challenges and her main concern was for the care of the needy. She died in 1958.

Stella Bradford, M.D. Born in 1871 in Montclair, Dr. Bradford graduated from Smith College in 1889 and traveled in Europe where she studied in Denmark, Italy, and Germany specializing in sociology. From 1895 to 1896, she taught elementary school in Elizabeth and was an assistant professor of English literature at Smith College. Dr. Bradford then entered Cornell University Medical College and graduated in 1902. After interning at Worcester Memorial Hospital in Massachusetts she returned to Montclair. In 1903, Dr. Bradford opened a private practice which lasted 52 years. She became a clinical assistant at Gouverneur Hospital, New York, and founded a tuberculosis clinic there in 1905. Dr. Bradford became interested in physical medicine and in 1932 was appointed director of that department at The Mountainside Hospital until her retirement in 1936. In 1950, she was called back from retirement to head the department and stayed until 1953. During her career she worked with handi-

capped children and adult patients with severe arthritis. Dr. Bradford established the first visiting nurse service in Montclair and the first fresh air school and tuberculosis clinic. In addition, she authored many papers in her field of rehabilitation medicine and was active in many professional societies. Dr. Bradford never married and died in 1959 at the age of 88.

Frances Bartlett Tyson, M.D. A descendent of Dr. Josiah Bartlett, a signer of the Declaration of Independence, Dr. Tyson was born in 1874 in Vineland. At 17, she tried to enroll in a nursing school but was told she was too young. She took a job in the pharmacy of Philadelphia's Women's Hospital and later graduated from The Philadelphia School of Pharmacy in 1896. Working as a pharmacist enabled her to earn enough money to complete a two-year premedical course at Temple University and to earn her medical degree from Women's Medical College in 1901. She practiced until 1909 when she married William Tyson, an insurance man, who persuaded her to quit practice; they had a daughter in 1910. In 1918, with World War I creating a physician shortage, Dr. Tyson tried to convince her husband she was needed in Leonia since all four local physicians were in the army. Yet it took the intervention of the town council to convince him: on his commuter train every day they complained how badly a doctor was needed. He ended up urging his wife to return to practice. During the influenza epidemic of that year, Dr. Tyson served the town practically single handedly, organizing women's clubs to help carry out feeding schedules for families with multiple victims. She herself fell prey to the disease and lost the hearing in her right ear. Dr. Tyson remained in practice, making housecalls in all kinds of weather. She solved the problem of climbing Leonia's icy hills by wearing her husband's galoshes fitted out with metal cleats. Her husband died of leukemia in 1948 after a long illness and she became the supporter of her family. In 1918, Dr. Tyson was appointed school physician and health officer for the town. She remained in this post long after her retirement from active practice—the school board simply refusing to accept her resignation at the age of 77. At the age of 83, Dr. Tyson was honored by the New Jersey Medical Women's Association as "Woman of the Year" in 1957. Greatly beloved by her colleagues and patients, Dr. Tyson remained active in volunteer work in her community until her death.

Marie Louise Lefort, M.D. Born in Newark in 1875, Dr. Lefort graduated from the New York Infirmary for Women and Children in 1898. In 1899, she was appointed district physician for the Old Newark Board of Health and served the city until 1918 when she volunteered to go to France to establish a hospital for gassed soldiers. Dr. Lefort remained in France at Rheims's American Memorial Hospital for 21 years and was awarded the French Legion of Honor for her work. She returned to New Jersey in 1939 to retire; and at the age of 82, Dr. Lefort died here in 1957.

Sara D. Smalley, M.D. A native of Newark, Dr. Smalley graduated from New York Medical College and Hospital in 1900. She established a general practice in Newark in 1901 and remained in practice until her death in 1952. Dr. Smalley was active with the Newark Equal Suffrage League and was a charter member of Zonta International, a noted women's professional organization, which also included Amelia Earhart as a founding member.

Vera Schectman, M.D. Born in Odessa, Russia, in 1884, Dr. Schectman came to the United States in 1906. She graduated from Women's Medical College in 1912 and came to Newark to practice. In 1926, she became the first woman physician on the staff of Newark Beth Israel Hospital and outraged some of her friends and colleagues in 1916 by giving lectures on sex education. Dr. Schectman was married and retired only a few years before her death.

Louise Pearce Skillman, M.D. Born in 1885, Dr. Skillman lived in New Jersey for 38 years. At one point she led an expedition through the jungles of Leopoldville, Africa; in 1915, she helped develop a drug, tryparsamide, used to treat African sleeping sickness. She was president of the AMWA in 1946. She died in 1950 at age 65.

Ella Coughlan, M.D. Born in 1886 in Hastings, Ontario, Canada, Dr. Coughlan had to fight her father's disapproval to enter medical school. As a result she began her career as a nurse, a common circumstance for many women physicians. When her father died and left her an inheritance, Dr. Coughlan immediately took premedical courses at the University of Toronto and entered Women's Medical College; she graduated in 1914. After interning in Women's Hospital she came to Orange as school physician where she served for 42 years. When the Salk vaccine against polio became available she almost single handedly saw to it that over 2,000 students received an injection. Additionally, she had a private practice in gynecology until 1948. She retired from medicine in 1951 and died some years later.

Linda Bauer Hauck, M.D. Born in Newark, Dr. Hauck graduated from Women's Medical College in 1914. In 1918, she joined the Public Health Service as a first lieutenant until World War I concluded. During this period she married and moved to Irvington where she practiced for over 40 years. Although forced to discontinue practice in 1943 because of poor health, Dr. Hauck collected clothing and food to send abroad to Holland, England, and France at her own expense. She was cited by the mayor of Walshein, Holland, for her aid to the distressed. Much beloved by her colleagues because of a gentle good humor and concern for young women entering medicine, Dr. Hauck was honored in 1957 as "Woman of the Year" by the New Jersey Medical Women's Association. Dr. Hauck died in 1964 at the age of 77, and both her son and daughter followed in her footsteps as physicians.

Rita S. Finkler, M.D. Perhaps one of the most distinguished women physicians in New Jersey, Dr. Finkler of Short Hills was born in Russia in 1888 to peasant parents. She began studying law at St. Petersburg University and shortly was thrown into prison for attendance at student anarchistic meetings. As soon as she was released from prison, Dr. Finkler came to the United States to continue her studies and changed her career to medicine. Graduating from Women's Medical College near the top of her class in 1915, Dr. Finkler made headlines by becoming the first woman intern at Polyclinic after placing in a competitive examination at Philadelphia General Hospital.

Dr. Finkler made the news when she rode the horse-drawn ambulance around Philadelphia with "poor old Jerry" pulling the vehicle; this amusing story of an ailing horse pointed out the need for a motor ambulance. Dr. Finkler, who spoke eight languages, spent the next several years studying abroad concentrating on endocrinology. Also, she practiced in Newark, writing over 70 papers in the field of endocrinology after establishing and heading the first such department of medicine in New Jersey at Newark Beth Israel Hospital. Although retired from practice after 55 years, Dr. Finkler continued to travel and lecture throughout the world until her death in 1968. She was honored as "Woman of the Year" by the NJMWA in 1956 for her work in 1947 as national chairwoman of the Emergency Committee of the AMWA which sent over 6,000 pounds of clothing, food, vitamins, and medical instruments to Europe to aid their colleagues.

Elizabeth Brackett, M.D. Born in New York City in 1892, Dr. Brackett was raised in Ridgewood, until 1912 when she entered nurse's training in New York. After graduation in 1915, she became an army nurse and served in France with an American unit attached to the British Expeditionary Force. It was in France that she decided to try to become a physician. After returning from France, she entered Columbia University, graduating in 1929 from the College of Physicians and Surgeons. After interning at Newark City Hospital and taking residency training in pediatrics at Children's Hospital, Philadelphia, and in Newark, Dr. Brackett set up a practice in Nutley over a corner drugstore. Finding that she could not support herself by just doing pediatrics, she became a general practitioner and surgeon with privileges at many area hospitals. In 1962, Dr. Brackett was honored by the NJMWA as "Woman of the Year" because of 30 years of outstanding sense of community welfare, never stinting of her time to her patients; never refusing a housecall until age and health forced her to do so. She actively supported the visiting nurse service of Nutley. Dr. Brackett was president of the NJMWA and was national treasurer of AMWA. Ill health forced her retirement in the 1960s, and she died in 1974.

Mildred Gregory, M.D. Born in 1884, Dr. Gregory was raised in Newark. She earned an undergraduate degree from Wellesley in 1916 and a master's degree in biology from Columbia, and taught at Skidmore College in Saratoga until 1924. Then she entered Columbia College of Physicians and Surgeons, graduating in 1928. After interning at Newark City Hospital, Dr. Gregory completed a residency in pediatrics at St. Mary's and Babies Hospital, Newark. In additon to practicing pediatrics in Newark from 1955, Dr. Gregory became medical director of Babies Hospital from 1949 to 1957 and was one of the first women diplomates of the American Board of Pediatrics. She was very active with the YM-YWCA of Newark and the Advisory Committee of the Essex County Clinic for Retarded Children. A quiet, unassuming woman, beloved by her patients and with outstanding professional ability, Dr. Gregory was named "Woman of the Year" by the NJMWA in 1961. She retired a few years later and died in 1975.

Jeannette Munro, M.D. Born in 1894, Dr. Munro was Princeton's first woman pediatrician and practiced there from 1933 to 1965. She was honored as "Woman of the Year" by the NJWMA in 1965. She recalls the era of $3 housecalls and $2 office visits or a dozen eggs. Dr. Munro originally had planned a career in social work but changed to medicine and graduated from the University of Wisconsin in 1927. She found herself resented as a "specialist" when she first opened her pediatric practice, but she soon won over her colleagues in Princeton by her dedication and professionalism.

E. Mae McCarroll, M.D. Described as the "first lady of the National Medical Association," Dr. McCarroll was born in Birmingham, Alabama, in 1898. Graduating as one of the first black women physicians from Women's Medical College in 1925, Dr. McCarroll interned at Kansas City General Hospital and after marriage in 1929 moved to Newark where she practiced for over 48 years. She was active in many civic and community affairs and led a Newark crusade in the early 1930s to stamp out venereal disease. In 1934, Dr. McCarroll was appointed a clinic physician in the venereal disease division of the Newark Department of Health. She did public health postgraduate study at Harvard. In 1946, Dr. McCarroll became the first black physician to be appointed to the staff of Newark City Hospital and she was named deputy health officer of the city. Dr. McCarroll was active for over 16 years with the National Medical Association and helped establish its journal as a true professional publication. She was honored in 1973 as that organization's "first lady." She currently is retired.

Anne Lardner Moore Shannon, M.D. Born in Pineville, North Carolina, in 1898, Dr. Shannon graduated from Cornell University Medical College in 1924. She did her postgraduate work in Europe and Manhattan General Hospital; and completed a residency at Bellevue in otolaryngology. Dr. Shannon became the first woman physician on the staffs of The Mountainside and Montclair Hospitals and the only woman surgeon. Dr. Shannon was a Diplomate of the American Board of Otolaryngology and a Fellow of the American College of Surgeons. Dr. Shannon died in 1960 after a long illness.

Carye-Belle Henle, M.D. Born in 1899, Dr. Henle received her medical degree from Columbia University College of Physicians and Surgeons. She became the first woman resident in radiology at Mount Sinai Hospital, New York City, where she met and married her husband, Dr. Harold Connamacher. In 1929, Dr. Henle purchased x-ray equipment and joined her husband in practice in Newark as New Jersey's first woman radiologist. In 1956, she was recognized by her colleagues by her election as the first woman president of the Radiological Society of New Jersey. For many years she was deeply engrossed in the long-range Radium Research Project of the New Jersey State Department of Health, seeking to determine the long-term effects of exposure to radioactive material. The subjects were radium dial painters of 1910 to 1920 in northern New Jersey. Dr. Henle was honored as "Woman of the Year" in 1963 by the NJMWA. She retired in the late 1960s and died in 1977.

Eva Brodkin, M.D. Born in Brooklyn, New York, in 1899, Dr. Brodkin was encouraged to become a physician by her father, Dr. Isador Topkins. She graduated

from Women's Medical College in 1924 and became the first woman intern at Muhlenberg Hospital, Plainfield. When Dr. Brodkin began her internship she was told she was an "experiment." She resolved never to take advantage of being a woman, but did everything asked of her including riding the ambulance and hauling stretchers. After entering general practice in 1925, she met and married Dr. Henry Brodkin, a thoracic surgeon. After her third child, she and her husband decided that a specialty would be better for her than general practice. For three years, six times a week, she took instructions in dermatology in New York; in 1931 she became New Jersey's first woman dermatologist. Dr. Brodkin was honored for her excellence in her specialty by her colleagues of the New Jersey Dermatological Society who elected her president in 1952. Dr. Brodkin was chief of the dermatology service at Saint Barnabas Hospital for many years. Her son, Dr. Roger Brodkin, currently is professor of dermatology at the New Jersey Medical School. Dr. Brodkin retired several years ago. She was honored as "Woman of the Year" by the NJMWA in 1964.

Jessie D. Read, M.D. Born in 1903, Dr. Read was a gynecologist and obstetrician in Essex County for over 50 years. She was a founding fellow of the American College of Obstetrics and Gynecology and a fellow of the American College of Surgeons. Dr. Read was one of the first women physicians commissioned in the Army from New Jersey in World War II and served as chief of surgery of a hospital unit in Europe from 1943 to 1946. She died in 1979.

Mary Bacon, M.D. Born in 1904, Dr. Bacon served Bridgeton on a daily 12-hour schedule in general practice as well as team physician for several local football squads from 1917 until her death several years ago. She was president of the Cumberland County Medical Society and first woman president of the medical staff of Bridgeton Hospital.

Lena Edwards, M.D. Born in 1900, Dr. Edwards continues a long medical career that began as a resident in obstetrics and gynecology at Margaret Hague Hospital, Jersey City. She graduated from Howard University. Despite the disadvantage of being female and black, Dr. Edwards has achieved numerous honors.

Camille R. Mermod, M.D. Born in 1901, Dr. Mermod was one of New Jersey's most distinguished women physicians. She graduated from Stanford University in 1932 and remained on its faculty from 1932 to 1938 as clinical instructor of medicine. From 1938 to 1943, she was director of the laboratory at St. Joseph's Hospital, Lancaster, Pennsylvania. She came to Newark as assistant pathologist at Saint Barnabas Hospital in 1942. During World War II she covered six hospitals in Newark and surrounding areas as a pathologist. After the war, Dr. Mermod entered the practice of internal medicine and stayed in that specialty until her retirement. She was chief of the department of medicine from 1955 to 1957. Dr. Mermod was a Diplomate of the American Board of Pathology and contributed many papers to the literature in the field of hematology. She was president of the American Medical Women's Association twice, 1954 to 1955 and 1956 to 1957. She edited the journal of the association for many years. In 1959, she was "Woman of the Year" in New Jersey and in 1965 she was awarded the Elizabeth Blackwell Medal by AMWA, its highest award. In 1964, she went to Italy as visiting lecturer at Bologna Medical School and in 1967 her alma mater, Mills College, California, conferred the honorary degree of Doctor of Laws upon her for outstanding work in scientific fields. In 1969, the AMWA announced a new award in Dr. Mermod's honor: a bronze medal encased in lucite given yearly to a layperson who has given outstanding service to the organization. Dr. Mermod died in 1976 at the age of 75 after a courageous fight with cancer.

Laura E. Morrow, M.D. Born in 1913, Dr. Morrow graduated phi beta kappa from Rutgers University in 1932. She completed her medical training at the University of Pennsylvania in 1937. After an internship in Lancaster, Pennsylvania, Dr. Morrow completed a psychiatric residency at St. Elizabeth's Hospital, Washington, D.C., and New Jersey Psychiatric Hospital in Greystone Park. She began her psychiatric practice in 1947 after five years in general practice and still has a very limited practice. Dr. Morrow was president of the AMWA in 1969 after many years of active committee service. She was awarded the Elizabeth Blackwell Medal in 1974 by the AMWA. She was the first woman president of the Passaic County Medical Society in 1972 to 1973 and the president of the Society of Clinical Psychiatrists of Northern New Jersey in 1965 to 1966. Dr. Morrow was married to Dr. J. Lloyd Morrow.

Virginia M. Love, M.D. The first black psychiatrist employed by Essex County in 1955, Dr. Love was a graduate of Howard University in 1950.

Jerene Robbins, M.D. A graduate of Hahnemann Medical College, Dr. Robbins was the first woman physician to be a college men's team physician at St. Peter's, Jersey City. She is a thoracic surgeon, one of the first in the state.

Emma M. Richardson, M.D. In 1918, Dr. Richardson fought to gain free medical care for prenatal patients to reduce high maternal death rates.

Edith D. Mangone, M.D. An obstetrician at Margaret Hague Maternity Hospital, Dr. Mangone advocated reduction of maternal deaths by control of puerperal infection, eclampsia, and hemorrhage. She wrote papers on these subjects.

REFERENCES

1. Cowen DL: *Medicine and Health in New Jersey: A History.* Princeton, NJ, D. Van Nostrand Co. Inc., 1964.
2. Lopate C: *Women in Medicine.* Baltimore, MD, The John Hopkins Press, 1968.
3. Flexner A: Medical education. Carnegie Foundation Report, 1910.
4. Brodie JJ: The woman physician in the United States today. *World Medical J* 25:28, 1964.
5. Conference on the Full Utilization of the Woman Physician: Facts on prospective and practicing women in medicine. Washington, D.C., 1968.
6. Nemir RL: Women in medicine during the last half century. *JAMWA* 33:201, 1978.
7. Marrett CB: Nineteenth century associations of medical women: The beginning of a movement. *JAMWA* 32:469, 1977.
8. Brodkin E, Haycock CE, Henle C, LiSooey E: History N.J. Medical Women's Association Branch Four, AMWA, 1972.
9. Walsh MR: Women physicians and World War II. *JAMWA* 32:189, 1977.
10. Teffean C: Sophia Presley, M.D.: The spinster who struggled seven years against bias of male doctors. *Bulletin Camden County Historical Society* 28:36, 1975.

THE JOURNAL OF THE MEDICAL SOCIETY OF **NEW JERSEY**

presents

300 YEARS OF MEDICINE IN NEW JERSEY

September 1984

We are celebrating the history of medicine in New Jersey. This special issue illuminates the beginnings of our health care system and the growth of medical care: essays highlight those talented individuals who devoted themselves to this system, and commentaries present the development of specialized care in associated fields of medicine. Plus a special photography section highlighting three statewide exhibits.

Copies of this issue are available by sending $5.00 (check or money order) to MSNJ, Two Princess Road, Lawrenceville, NJ 08648. All MSNJ members will receive one copy of this issue.

Name_____

Address_____

_____

Enclose a $5.00 check or money order for each copy.

A Medical Dynasty in New Jersey

Estelle Brodman, Ph.D., Hightstown*

There was a large number of physicians practicing in Hightstown in the late 19th and 20th centuries. A preliminary investigation showed that no fewer than 15 physicians practiced there from 1886 to the end of World War I. Four families provided most of the medical care through two generations.

A very large number of physicians practiced in Hightstown in the late 19th and early 20th centuries. It would seem that a borough as small as Hightstown could not have been able to support more than a couple of physicians, for at no time during this period did the population rise above 2,750 people. A preliminary investigation of the directories of American physicians from 1886 to 1920, however, showed that no fewer than 15 physicians practiced in Hightstown from 1886 to the end of World War I. Usually, there were 5 physicians listed for any one year, but occasionally there might be 6 or even 7. Moreover, many neighboring smaller communities, some of them now incorporated into the Hightstown area, provided other physicians, who now and then moved into "the city" (Hightstown) as they grew older; so actually there were more physicians available to Hightstown patients than the official directories would seem to indicate.

Another finding was that four families provided medical care through at least two generations; one of these families had three physicians (including one woman) and three trained nurses during this period.

In this paper I shall describe some of the conditions which led to the medical situation described, give some biographical information about several of the physicians, and then examine the Silver family dynasty of physicians, and especially, Dr. Sarah C. Silver-White.

HISTORIC HIGHTSTOWN

Hightstown is an old gristmill town, founded originally in 1721 on the post road which ran from Camden through Bordentown to Perth Amboy, connecting with ferries to Philadelphia at the Camden end and with New York at the Perth Amboy end. Intersecting the Camden to Perth Amboy Road near Hightstown was the road to York, Pennsylvania, through Trenton. (Both roads were important in the battles of the Revolutionary War, and a tavern for weary travelers soon sprang up at their intersection. By 1835, Hightstown had a post house for the stage line between Princeton and Freehold; later there were four hotels for travellers.)

Hightstown continued to be important in the commerce between New York and Philadelphia throughout the 19th century, partially because one of the earliest American railroads, the Camden and Perth Amboy Railroad, ran through town. In addition to the Camden and Perth Amboy Railroad, the Union Transportation Company and the Pemberton and Hightstown Railroad (later part of the Pennsylvania Railroad system) ran through or near Hightstown. So important was the railroad business to the town that the local newspaper,

*Dr. Brodman is a Librarian and Professor of Medical History Emerita, Washington University School of Medicine, St. Louis, MO.

the *Hightstown Gazette*, regularly carried a column, "Railroad Doings," which noted changes in personnel, schedules, prices, sales, and accidents. In addition, 2 of the 15 physicians listed primarily were railroad surgeons, rather than full-time Hightstown residents' physicians.

While the railroad was the hub for the agricultural wealth of the surrounding area—rye, wheat, other grains, potatoes, and apples—it also allowed physicians to see patients who lived at a distance; either by themselves going to the patients in other vicinities, or by having patients come on the railroad for appointments with Hightstown doctors. By 1906, when the first automobile was purchased by a Hightstown physician, the catchment area for patients had expanded enormously from the early days.

MEDICAL CONDITIONS

Because of its geographical position, halfway between New York and Philadelphia, the influence of these two cities on Hightstown was considerable; yet neither city was dominant over the other. Looking at the education of the 15 physicians under study, we find 6 were trained in medical schools in Philadelphia, 4 in New York, 2 in Maryland, 1 in Ohio, and 2 in unknown places. As was to be expected, the earlier physicians were more likely to train in Philadelphia and the later ones in New York as that city's schools began to equal their Philadelphia rivals.

Like many other areas in New Jersey, Mercer County had few hospitals until World War I. Trenton was the only Mercer County city with any hospitals at all in 1890: St. Francis Hospital (founded in 1873), the Trenton City Hospital, and the Trenton Eye and Ear Infirmary. Accidents and serious illnesses were treated at home or in the local doctor's office, while many operations still were being performed in farmhouse kitchens and dining rooms. Quarantine was practiced for school children, but not always observed carefully. In 1897, according to the *Transactions* of the Medical Society of New Jersey for that year, Mercer County had 222 cases of diphtheria with 44 deaths; although some toxin-antitoxin vaccine was available as a preventive, where it was used the mortality rate from diphtheria fell from 32.6 to 7.6 percent; 56 cases of scarlet fever; and 100 cases of typhoid fever. In 1886 the local newspaper reported that nearly every youngster in town had whooping cough; in 1890, it reported that "our doctors are unusually busy with cases of influenza, although the town itself is not furnishing many of their patients"—which again shows that the patient population extended far beyond the town itself. But by this time the telephone and electricity were coming into the town, easing the work of all.

Finally, the local drugstore was advertising not only that it sold paints and varnishes as well as drugs and patent medicines (good for man or beast), but that, as the newspaper noted on February 23, 1888, "Probably no one thing has caused such a general revival of trade at Cunningham's Drug Store as their giving away to their customers of so many free trial bottles of Dr. King's New Discovery for Consumption."

As might be expected, medicine in Hightstown in this period was divided by sects as much as in other areas of the nation with several homeopathic physicians and one chiropracter. The physician was likely to be judged by his performance rather than his background philosophy, and at least two of the homeopathic physicians were accepted by both the public and the medical practitioners, as well as the state licensing bodies, even though the state medical society did not encourage homeopaths to become members. Dr. George H. Franklin, for example, practiced in Hightstown for some 30 years as a homeopathic physician, as did Dr. Sarah Silver White who came back to Hightstown after practicing homeopathy elsewhere and was accepted without question.

BIOGRAPHICAL SKETCHES

Although there were 15 physicians practicing in Hightstown from 1886 through World War I, there were really only 4 who stayed for any length of time: Doctors George H. Franklin, Joseph P. Johnson, George E. Titus, and Lloyd Wilbur.

Dr. George Henry Franklin was born in 1856 and received his medical degree from the Columbia University College of Physicians and Surgeons, New York, in 1879. He practiced for a few years in Windsor, a neighboring town; in 1886, he moved to Hightstown and remained there the rest of his life. Although the general practice of physicians at that period was to take care of all cases—and the *Hightstown Gazette* certainly reports his work in cases of accidents and in epidemics—Dr. George Franklin reported to the American Medical Association in 1906 that his practice was limited to obstetrics and gynecology. There is nothing in the local archives that would clarify this point; on May 29, 1890, the local newspaper reported that he had purchased an oxygen generator and planned to use the gas in chronic lung diseases, bronchitis, incipient consumption, and severe cases of dyspepsia and rheumatism. Perhaps he changed to specialization between this date and 1906, but that is speculation. Dr. Franklin also was a joiner; as an ardent Methodist he attended many of the church's annual conferences, and he frequently talked to the Baptist Men's Club on medical and moral subjects. On February 7, 1910, for example, he spoke on tuberculosis, then a potent killer in Hightstown. He was on the town council, elected on the "Improvement Ticket" in 1900, and he served for a time as school medical inspector. He called the home and office he built in 1910 on Main Street a bungalow, which still stands.

Dr. George H. Franklin had one son, Charles Montange Franklin (1881 to 1918), who graduated from University of Pennsylvania Medical School in 1906. "Monty" Franklin typified the education of Hightstown physicians, for the family was divided, with one member going to New York for medical training and the other to Philadelphia; although usually it was the older physician who had the Philadelphia degree and the younger the New York one. Like his father, Dr. Charles Franklin claimed a specialization—his practice was limited to pediatrics, complementing, no doubt, his father's obstetrical work.

The younger Dr. Franklin was one of the town's gay blades, for the newspaper reports a number of his actions as a young boy and later as an adult, when he



Figure 1—Home and office of George E. Titus, M.D.

and his wife gave rather elaborate dinner parties. Unfortunately, however, he died during the flu epidemic of 1918 when he was only 37 years old.

The second long-acting Hightstown physician was Dr. Joseph P. Johnson, a homeopathic physician who was graduated from Hahnemann Medical College, Philadelphia, in 1867 and practiced in Hightstown until 1912. In addition to his medical practice, of which details are meager, he was a member of the school board and clerk of the district for 20 years. When he declined to run again, in 1900, the *Hightstown Gazette* noted, "He has done an immense amount of hard work and shown a deep and intelligent interest in our public schools." On March 20, 1890, "sealed bids for doctoring the poor of the township were presented [to the Township Board] and the contract was awarded to Dr. J.P. Johnson as the lowest bidder at $43.50." Whether his contract was awarded him annually thereafter is not known, nor are his duties spelled out. As a homeopath, Dr. Johnson was not a member of the county or state medical societies, but he certainly was accepted by the townspeople with the same enthusiasm that they accepted the other long-term practitioners.

The third long-term Hightstown physician, Dr. George E. Titus (1855 to 1916) and a graduate of Bellevue Hospital Medical School, class of 1877, probably was the most sanitarian-like physician of the group. He persuaded the town to put in a filter system for its water supply and later a sewer system. On January 4, 1900, he was authorized, as chairman of the town's Finance Committee, to arrange for certificates of indebtedness of $2,500 to pay for the filter and he made regular reports on the matter. He also was active as a member of the County's Republican Committee for a number of years, where he tried to have sanitary measures put into legislation. Soon after he came to Hightstown, he erected a handsome house and office (Figure 1), which still stands on Main Street, in which he lived until his death in 1916.

Dr. Lloyd Wilbur (1831 to 1900), the last of the long-term physicians, represents a bridge from the older education and practice of medicine in the early 19th century to the newer systems of the late 19th and 20th centuries. He was born in 1831 in a rural portion of the state and was educated at the Trenton Academy and the Pennington Seminary, from which he was graduated in 1848. He taught school near there for two years while also studying medicine under Dr. George F. Fort of New Egypt as preceptor. (Fort later became governor of New Jersey, showing how medicine and politics still were possible joint occupations at the time.) In 1853, Lloyd Wilbur entered Jefferson Medical College, Philadelphia, from which he obtained his degree in 1854 after the usual two-year course. Later, Princeton University awarded him an honorary master of arts degree for his civic as well as medical efforts.

Dr. Wilbur was an ardent abolitionist, and was a member of the Republican delegation to the convention which nominated Abraham Lincoln for the presidency. He was Superintendent of Schools for Mercer County for six years, and State Superintendent of the School Census until that office was abolished by the legislature. In 1887, the borough of Wilbur was named for him, now a part of Trenton.

Wilbur's medical practice is better documented than that of the other physicians. His ledger of patients and charges made has been preserved and is in the Hightstown Historical Society. Since primarily it is a fiscal accounting, the ledger does not give all the medical details which we would like to have; moreover, it covers a period when he was just beginning his practice (1857 to 1860). There are enough data in the book to derive some conclusions about his practice—and, therefore, probably the practice of other physicians in small towns at that time.

Since Dr. Wilbur bought the practice of a Dr. Blauvelt in 1855, it is possible that he inherited some of that physician's clientele. I have tabulated his records for the first three weeks of August, for 1857, 1858, and 1860:

1. He saw from 1 to 10 patients a day, growing steadily busier. In 1857, his average load was 2.95 patients/day; in 1858 it was 3.3/day, while in 1860 it was 4.6. The latter year must have been a particularly sickly one, because he listed more than 4 patients/day on 6 of 21 days, some even on Sunday, and he had several 10-patient days.

2. He saw the same patient on the average of five consecutive days, after which it is presumed the patient was discharged.

3. His usual charge for a visit and medicine, or a visit and advice, was 50¢. A visit to two patients in a household varied from 75¢ to $1.50. Night calls were $2 to $5, and obstetrical cases were $5. Variations occurred, of course; clergymen were not charged anything and colored patients 12½¢ a visit. It should be emphasized, of course, that these were just his charges: payments were rarely as much as the ledger indicated, and here and there barter payments in-kind were noted—grain, chickens, and ham.

4. Occasionally, the disease and/or its treatment is listed. Some causes for the fees are given, as: removal of foreign body or "accouchement uxoris" (billed, of course, to the husband). Tincture of opium was given to one patient who was charged 37½¢, though spirits of ether cost another patient 50¢ and Hydr. chlor. and Acet. Potass. each were only 25¢. An incision of the avcolar (perhaps lancing a boil on the gum) cost one father another 50¢ and extracting a tooth cost another

husband 25¢. A spontaneous abortion caused Dr. Wilbur to ask one husband for $1 and another husband for $2. Tincture of digitalis was prescribed; morphine was injected; a case of tetanus treated; neuralgia was listed once; and diarrhea and convulsions each once. He adjusted a fracture of the clavicle for one patient at a charge of $5, while seven consecutive visits to the unnamed "milkman" with an unlisted disease were charged at $5.50.

Dr. Lloyd Wilbur died on January 27, 1900, and received a two-column obituary in the local paper and a funeral attended by patients and other physicians from throughout New Jersey. The Medical Society of New Jersey representative characterized Dr. Wilbur as a truly accomplished practitioner with a vice-like memory, accustomed to constant study and often in consultations with the foremost doctors of the country. His ideas and opinions were said to be clear-cut; in surgery he was found to be original, dextrous, and resourceful. The lay paper commented on his humane qualities: "Under a natural brusqueness of manner, he concealed a heart that was as tender as a woman's, and his notable indifference to charging fees or collecting bills has made many a poor man and woman call his name blessed."

Dr. Wilbur had two sons, both of them physicians. The older practiced in Asbury Park and the younger continued his father's practice in Hightstown. Dr. William Wilbur, the younger son, was a graduate of the University of Pennsylvania in 1888 and returned to practice in Hightstown until 1906 and again after 1918. Like his father, he was a politician as well as a physician, being sheriff of Mercer County for a number of years and finally becoming president of the New Jersey Sheriff's Association. He moved to Trenton in 1906 and practiced there as well as in Hightstown for some years. While in Trenton, some of his Hightstown patients came to that office on the train and by bus, according to one resident. Dr. William Wilbur made several foreign trips—to London and Paris three months after his father's death, and then continued on to Oberammergau for the Passion Play. He was certainly up-to-date, going to New York for the Automobile Show of 1906 and buying a Buick for himself.

SILVER FAMILY MEDICAL DYNASTY

The Silver family (Figure 2) contributed the most medical and health-related care to the residents of Hightstown during this period.

The oldest member of the group was Dr. George Addison Silver (1861 to 1944) (Figure 3), a graduate of the New York University Medical College in 1881. For some years he was in practice in Butler, Morris County; then he moved to Windsor, the suburb of Hightstown, where he practiced until he came to Hightstown in 1909.

Dr. George A. Silver's son, Dr. E. Drew Silver, born in 1889, received his medical degree from the College of Physicians and Surgeons in Baltimore in 1913. During World War I he served in the Medical Corps assigned to the British Black Watch. While in Europe, his wife and daughter continued to live in Windsor, often visiting Hightstown for Sunday family reunions. After returning from the War, Dr. E. Drew Silver (Figure 4) moved his family and practice to Hightstown.



Figure 2—Silver family photograph.

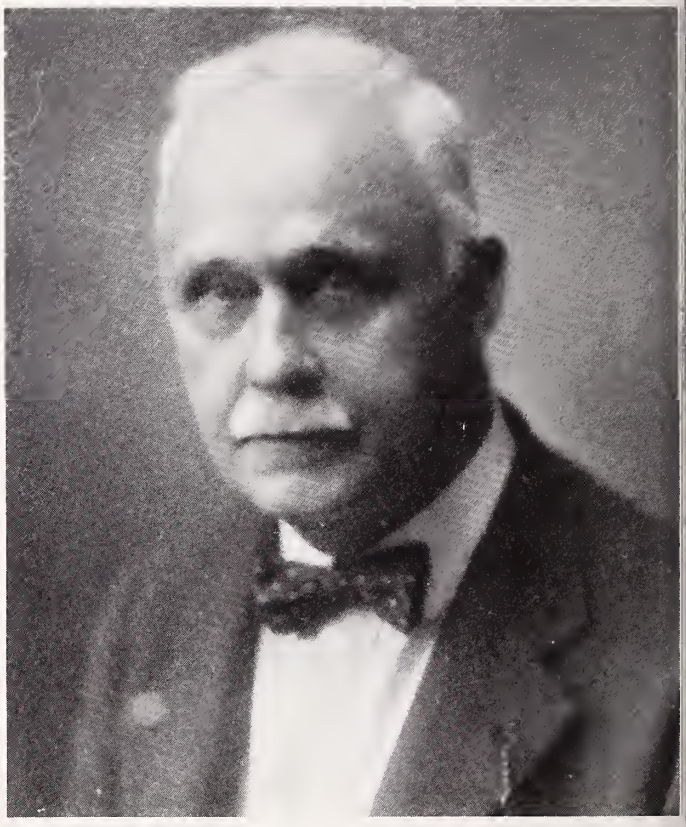


Figure 3—George A. Silver, M.D.

Three of the Silver family women became nurses: Josephine Drew Silver, Jane Amanda Silver, and Marie Pullen Silver. The New York-Philadelphia education balance can be seen in the training of these three women: Josephine and Jane Amanda were in the second class of the newly formed Nurse's Training School at Bellevue Hospital, New York. Marie was a graduate of the Philadelphia's Women's Hospital. During World War I, Jane Amanda nursed in Gouverneur Hospital, New York, and later became office nurse for her sister. Marie Pullen Silver was the wife of Dr. E. Drew Silver.

One can only speculate whether these three women who became nurses just before the turn of century might not have wished to enter the medical profession directly, but were constrained by the mores of the time and the consequent difficulty of finding a reputable medical school that would take medical students. I call to your attention the fact that women's medical schools proliferated because no other way of obtaining



Figure 4—E. Drew Silver, M.D.

a medical education existed, with even Johns Hopkins Medical School playing tricks with the money Mrs. Garrett gave them on the condition that they admit women equally with men, to emphasize the frustrating position of the women in the Silver family who might have had the same bent as their male siblings.

One of the Silver women, however, did not follow the line of the acquiescing females—she became a physician on her own after some years as a nurse and practiced medicine for 38 years in New York and several New Jersey cities. She was Sarah Cubberley Silver, M.D.,—after her marriage, she practiced as Silver-White.

Born two years after her brother, Dr. George Addison Silver, Sarah Silver (1863 to 1933) was graduated at age 32, in the 1895 class of the New York Medical College and Hospital for Women, a homeopathic institution which had been founded in 1863; the College had 16 professors, 4 assistant professors, 6 lecturers, 1 demonstrator, and 1 assistant demonstrator—both men and women—on the faculty when she was a student there. Unlike many of the medical schools of the time, this one had a 4-year graded course with a 26-week academic year, and advertised it had laboratories for the study of anatomy, histology, and clinical medicine. Matriculants were expected to have a college degree or have passed the New York State Regents examinations, although like many medical schools of the time, the stated requirements and the actual ones probably differed. For the period, however, this school was at least as good as many of those which accepted men only.



Figure 5—Sarah C. Silver-White, M.D.

For almost a year after her graduation Sarah Silver remained at the hospital run by the medical school in New York City; in 1896, she moved to Paterson. From 1896 to 1902, she lived at four different addresses in Paterson. At that point she returned to New York City and practiced under her married name, Silver-White, at three different places through 1909. By 1912 she was resident in Passaic, and had two different addresses in that city until, after a heart attack, she returned to practice in Hightstown in 1916; but even in that town she managed to live at three locations until her death at 70 years of age in June 1933 of a brain tumor. She ceased to practice in 1930. When asked about all these changes of address, her grandniece said Dr. Sarah was a perfectionist; for her nothing was ever right. The niece also admitted, however, that Dr. Silver-White was a very difficult woman to get along with at any time, and that probably accounts for her moves (Figure 5).

Apparently, Dr. Silver-White was a good physician, even if a peculiar one, and adored by her patients. There is one story told about how she visited a sick child in the country and went out of the farmhouse to speak to the child's father who was plowing. To her surprise, however, she found that the father also was ill with the same high fever, and she ordered him to go home and go to bed. When he complained that he must finish his ploughing first, she told him to go home—she would do the rest of the ploughing, and she did!

Patients that she had treated at her Paterson or Passaic practices still came to her in Hightstown for medical help, using the railroad until buses and automobiles came in. For that reason she had her office close to the railroad station and is reputed to have learned the railroad timetables by heart. Her sister, Jane Amanda, the trained nurse, acted as her office nurse, and is said to have made the patients' and the local merchants' lives easier than did her rather short-tempered sister.

CONCLUSIONS

What final conclusions can we draw from this tale of local New Jersey physicians in the decades around the turn of the 20th century? I think we can conclude that:

1. While none of the physicians I have discussed made any great additions to medical knowledge or published or experimented anything notable, they represented the ideal of the family physician which in today's world is so difficult to find.

2. Even in small towns in New Jersey, the physicians generally were well-educated, either in allopathic or homeopathic medicine.

3. Most small-town physicians were general practitioners, and even those who stated that they limited their practice were expected to remain the family physician as well.

4. The practice of medicine at that time was not so compelling but that physicians had time to take or civic, religious, and societal roles not so common today

5. As communication and transportation methods grew better, the catchment area for physicians to draw patients enlarged greatly. The railroad was the principal aid here until the time when the public transportation bus and the automobile became competitive.

6. Women still were being relegated to supporting roles in medicine at this time, although an occasional woman physician can be expected.

7. Just as tradesmen and craftsmen tended to pass on their skills to their sons, so physicians often built medical dynasties.

The Academy of Medicine of New Jersey: A Brief History

Morris H. Saffron, M.D., Lawrenceville*

The Academy of Medicine of New Jersey (AMNJ) is a beacon of enlightenment for the practicing physician. From its beginnings to the present time, AMNJ has worked for the dissemination of medical information.

When the Academy of Medicine of New Jersey (AMNJ) was founded in 1911, New Jersey, one of the few remaining states without a medical school, was a professional wasteland. Only Newark City Hospital had acquired national recognition as a center of medical education. The fathers of AMNJ, who included the most distinquished physicians of northern New Jersey, made it clear from the very start that the primary purpose was "the dissemination of medical information to the profession and the public." From this objective, AMNJ never has waivered and decades before the concept of an enforced CME was even considered, the organization had become a beacon of enlightenment for the practicing physician.

AMNJ was founded in Newark and originally was called the Academy of Medicine of Northern New Jersey. Its purpose was to provide a place for scientific meetings where practicing physicians could continue their education. An eyewitness account from an early publication describes the beginning:

> "It was one cold, wintry night on February 25, 1911, that some determined, dedicated knowledge-thirsty doctors came streaming into the Newark public library, some walking across Washington Park from the fashionable houses, that, in those days, were located in the downtown section of Newark. Some came on bicycles, some in buggies, and some chugged along Washington Street in high-fendered, open-top automobiles. They came from Newark and Jersey City, Hilton and Communipaw, Elizabeth, and Vailsburg. By ten o'clock there were nearly 100 of them, crowded into a shelf-lined corner, perched on chairs and stools and book boxes, eager to give the breath of life to the age-old idea of an Academy of Scholars."

This formal debut of the Academy brought together a distinguished group of men. Dr. Edward J. Ill, the distinguished surgeon and humanitarian, was the first president. The early meetings were held in the first home of the Academy, the Wiss Building at 671 Broad Street, and the roster of speakers during the early days indicates the high standards set by the founders. The first formal address was given on November 2, 1911, by Dr. John B. Murphy, the famous Chicago surgeon, then president of the American Medical Association.

But the main purpose of the Academy—the opportunity for free and open discussion—could not be served through formal lectures alone. April 19, 1911, saw the formation of four original sections: medicine; surgery; obstetrics and gynecology; and ear, nose, and throat. In 1915, pediatrics became a new section. By 1950, three additional sections were added: general practice; oral medicine and surgery; occupational medicine and hygiene; additional sections since have been added.

*Dr. Saffron is Guest Editor of this special issue.

THE EARLY YEARS

Academy President August Strasser left in 1917 to serve in the armed forces; the Academy was left under the able administration of Harrison Martland, M.D. Six scheduled meetings were cancelled because no quorum was available (wars notoriously have harmful effects on voluntary organizations) and the only large conference held was that of the pediatric section. The shortage of physicians was felt more keenly because of the calamitous influenza epidemic which ravaged New Jersey during 1918 and 1919. This menace brought forth on February 19, 1919, one of the greatest symposia ever held at the Academy; the entire subject of influenza was covered from every conceivable aspect.

During these troubled years the Fellows never lagged in the pursuit of a permanent home for the Academy. President Harry B. Epstein led a successful campaign for subscription funds for the purchase of a brownstone facing Lincoln Park, and on October 20, 1920, President John F. Haberty opened the doors to a brilliant assembly (Figure 1).

By an agreement signed May 18, 1921, the Medical Library Association was merged formally with the Academy, and the books were transferred to the new building. With the acquisition of a handsome home and fine library—then valued at $10,000—the Academy entered on the second prosperous phase of its history.

With inadequate financial resources, the 18-year-old Academy was ill prepared to meet the depression years of 1929 to 1933. Mass resignations reduced revenue to such a degree that a committee was formed belatedly to obtain funds for a permanent endowment. Still, in 1930, the Academy voted to send a gift of books to the library of the newly opened Temple University School of Medicine, a brave gesture in those difficult times.

Between 1935 and 1937, President Max Danzis began an intensive public relations program which brought thousands of lay people to Academy meetings. By 1936 signs of true recovery were in evidence. The city of Newark resumed its financial support of the Academy Library, discontinued in 1933.

With improving economic conditions, 1937 also saw an unequalled rise in the number of new members. In a drive sparked by President Henry C. Barkhorn, over 100 new Fellows joined, bringing the total to 474.

In 1939, on the 85th birthday of Dr. Edward J. Ill, an award bearing his name was established by the Academy (Figure 2); the honor is bestowed annually upon a New Jersey physician for dedication and extraordinary service to the profession and citizens of the state.

THE 1940s

The 30th anniversary of the Academy was highlighted by the announcement of the Eagleton gift on March 18, 1941: the brownstone adjacent to the Academy home—doubling the space for the library and meetings. With the acquisition of the Eagleton House rose the necessity of integrating the two structures—accomplished by 1942.

The years of World War II brought serious problems and drastic changes. The Academy founding fathers were becoming too ill and feeble to continue in active service. Since the majority of youthful Fellows were called to active duty, the roll of dues-paying members fell to a distressingly low point. Under the administration of Dr. Royal S. Schaaf (1944 to 1945), the downward trend in membership was checked.



Figure 1—The Academy's first permanent home.

In September 1945, President Lee Hughes acted as host at a formal reception to returning war veterans. These men came back with an insatiable appetite for knowledge, determined to resume their studies, and to embark on a career of specialization.

THE 1950s

The years 1951 and 1952 saw several large acquisitions by the library: 1,000 volumes from the library of Dr. Edgar Cardwell; 1,500 volumes from Princeton University; and the entire collection of the defunct Essex County College of Medicine and Surgery. In anticipation of a move from Newark to a more accessible suburban area, the agreement with the Newark Library was terminated.

On March 5, 1953, the name of the Academy was officially changed to the Academy of Medicine of New Jersey (AMNJ).

On January 7, 1954, Dr. Herbert A. Schulte reaffirmed the position of the Academy stating: "Postgraduate education be considered a fundamental function of the Academy, that our efforts and capacities be extended through existing or new avenues to correlate and integrate all our activities to make them available throughout the state, and that we implement programs in order to avoid duplication and inevitable dispersion of interest on the part of the medical profession." This led to the formation of a committee on education.



Figure 2—Wells P. Eagleton, the first recipient of the Edward J. Ill Award.

On April 7, 1955, the Academy established the "Citizen's Award," to be given annually to a New Jersey resident for extraordinary individual services for the health and welfare of the general public."

In October 1959, the Academy moved to Bloomfield, to larger quarters.

THE 1960s

When Dr. Morris Saffron was president (1965 to 1966), MSNJ had begun to give some financial support to the Academy library, yet there still was no formal understanding relative to postgraduate education, a subject in which both organizations were vitally concerned. Drs. Parsonnet, Bernhard, and Saffron eventually gained financial assistance from the Medical Society for expansion of an educational program—an allocation to support visiting symposia. The Academy was on the way to its present supremacy as a center for the dissemination of medical information.

During the term of Dr. W. Franklin Keim as president (1967 to 1968), the first presentation of the William P. Burpeau Award, established by the section on urology as a memorial to a New Jersey leader in this specialty, was made; the award since has been given annually to an impressive list of urologists from foreign countries as well as our own.

THE 1970s

As the Academy entered what has proved to be the most eventful decade of its history, it already had attained a position of leadership as the most influential force in the field of continuing medical education (CME) with the help of Dr. Milton Shoshkes who was carrying CME programs to unprecedented heights. Yet despite the continued rise in membership, the Academy still found itself in a chronic state of financial difficulty. With minimal endowment, AMNJ depended on dues for 90 percent of its budget, more than $50,000 of which went to support the library. Although this was the rock on which the Academy had been founded, and a continuing source of pride when it was the only major collection in New Jersey, it rapidly was being surpassed by the two libraries of the state-supported medical schools. Finally, the actual transfer of some 40,000 volumes to Newark was necessary and effected; the rare books were appraised and the collection was deposited for a five-year period in Newark, with the understanding that it could be recaptured in the event that the Academy found suitable quarters.

In December 1970, the Board adopted a resolution prepared by Dr. Henry Davidson, outlining the Academy's obligations as the recognized educational arm of MSNJ. The Academy agreed to consult with and present annual reports of its activities and expenditures to the Committee on Education of the Medical Society, which would have representation on the Academy Board; Dr. James A. Rogers was the first liaison member.

At the same time, the *Bulletin*, the Academy journal started in 1955, was published for the last time—another sacrifice to economic necessity; it contained six articles on various aspects of New Jersey medical history.

When Dr. Sherman Garrison assumed the office of president (1971 to 1972), the unsatisfactory fiscal status demanded his immediate attention. He appointed Dr. Leo Siegel to head a committee to negotiate with potential buyers for the sale of the Bloomfield property, and terminated all library activities. AMNJ played host to a team sent out by the AMA to survey programs; on August 7, 1972, the Academy received approval as a category I sponsoring organization for a period of four years. At the same time MSNJ instituted a mandatory requirement of 150 hours of approved study every three years for continuing membership. Taking note of these rapid developments in the field of education, Dr. Siegel voiced his determination that the Academy maintain its leadership in CME, urging younger Fellows to advance new ideas for consideration.

In the spring of 1973, Charles Heitzmann was appointed Executive Director with Linda Bartolo as his Associate.

In 1973, the Academy moved to Union. Located some 15 miles south of Newark, the Academy had left Essex County for the first time, thus demonstrating its determination to serve physicians from every part of the state. Union was to remain the "interim home" for six years, during a period marked by unusual activity and growth.

Upon the death of Dr. Henry Davidson in the summer of 1973, Dr. Arthur Bernstein assumed the presidency and served another term, 1974 to 1975.

In 1974, the Academy of General Dentistry gave its approval to the Academy as their statewide accrediting body. This year was also a time of expansion of services to speciality societies, and in 1984 there are 28 specialty societies being served by the Academy.

The presidency of Dr. Leon Smith (1977 to 1978) coincided with a period of unusual growth of membership and activity, and has been called the most productive year in Academy history. During this year there were no less than 12 major symposia, some 200 roving symposia, and 900 cosponsored meetings.

During his term in office, President James A. Rogers (1978 to 1979) addressed several messages to the Fellows in which he touched on CME, the increasing incursion of government bureaucracy in the practice of medicine, the escalating cost of the health delivery system, and the necessity for the profession to collaborate in presenting a solid front against detractors.

In view of the increasing number of specialty societies affiliated with the Academy in1979, it had been suggested that AMNJ sponsor a New Jersey Association of Medical Specialty Societies. This group was organized on February 14, 1979, and thus became an added force supporting the efforts of organized medicine to keep CME under the direct control of the practicing physician.

In September 1979, after six years in Union, the Academy finally moved to the headquarters of the Medical Society of New Jersey in Lawrenceville. The advantages were manifold: adequate parking facilities; ample office space for the expanding staff; conference rooms; an auditorium seating 400; a dining area; and storage room. Of even greater significance was the fact that the Academy, now officially designated as the educational arm of MSNJ, could work closely with the administrative staff of that Society. Finally, this central location symbolized a determination to become an Academy for all of New Jersey.

THE PRESENT YEARS

AMNJ, with 2,200 members now is actively studying the new developments in computer technology to see whether they can be adapted to home and office use as educational tools. Thus, AMNJ is planning to offer audio cassettes to Fellows which will include the more important symposia. And for the general public there is a roster of 80 speakers who can discusss health topics before clubs and other civic groups. Finally, AMNJ Past-President, Dr. Paul Hirsch, instituted regular luncheon meetings devoted exclusively to nonclinical socioeconomic topics and these already have proved to be a new and successful development.

CONCLUSION

The perceptive words of Dr. C.M. Robbins, written 50 years ago, sum up the history and purpose of the Academy: The very existence of the Academy is a token of our interest in keeping ourselves members of a learned profession, and so long as we are a genuinely learned profession, we can take pride in our title and need fear no commercialization, no cheapening, no regimentation. But no one can merit the designation 'learned' nor keep the respect of an increasingly science-conscious public if he lets his reservoir of technical knowledge become obsolete. And here is the real function of our Academy: To furnish a forum for scientific discussion, a channel for the newest medical and dental data, a training center for the intellectually curious and the tools for the resharpening of our professional wits."

BALANCED CALCIUM CHANNEL BLOCKADE!



Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

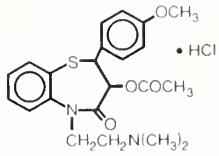
Please see full prescribing information on following page.

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash asthenia (1.2%), AV block (1.1%). In addition, the following were reported infrequently (less than 1%) with the order of pr tion corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, b dia, palpitations, congestive heart syncope.
Nervous System:	Paresthesia, nervousness, somn tremor, insomnia, hallucinations, and a
Gastrointestinal:	Constipation, dyspepsia, diarrhea, v mild elevations of alkaline phosphatase SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photose
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing epis vasospastic angina developed periods of transient asymp asystole approximately five hours after receiving a single dose of CARDIZEM.

The following postmarketing events have been reporte quently in patients receiving CARDIZEM: erythema multifor kopenia; and extreme elevations of alkaline phosphatase SGPT, LDH, and CPK. However, a definitive cause and effect these events and CARDIZEM therapy is yet to be establish

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been Single oral doses of 300 mg of CARDIZEM have been well t by healthy volunteers. In the event of overdosage or exag response, appropriate supportive measures should be emp addition to gastric lavage. The following measures may be con

Bradycardia	Administer atropine (0.60 to 1.0 mg) is no response to vagal blockade, ad isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixe degree AV block should be treated v diac pacing.
Cardiac Failure	Administer inotropic agents (isopro dopamine, or dobutamine) and diureti
Hypotension	Vasopressors (eg, dopamine or leva bitartrate).

Actual treatment and dosage should depend on the severi clinical situation and the judgment and experience of the physician.

The oral/LD_{50}'s in mice and rats range from 415 to 74 and from 560 to 810 mg/kg, respectively. The intravenous these species were 60 and 38 mg/kg, respectively. The ora dogs is considered to be in excess of 50 mg/kg, while letha seen in monkeys at 360 mg/kg. The toxic dose in man is no but blood levels in excess of 800 ng/ml have not been as with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerot nary Artery Disease or Angina Pectoris at Rest Due nary Artery Spasm. Dosage must be adjusted to each needs. Starting with 30 mg four times daily, before meal bedtime, dosage should be increased gradually (given in doses three or four times daily) at one- to two-day interv optimum response is obtained. Although individual patie respond to any dosage level, the average optimum dosa appears to be 180 to 240 mg/day. There are no available data ing dosage requirements in patients with impaired renal o function. If the drug must be used in such patients, titration s carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abo anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may b coadministered with short- and long-acting nitrates, have been no controlled studies to evaluate the an effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 1 0088-1771-47) and in Unit Dose Identification Paks of 1 0088-1771-49). Each green tablet is engraved with MARIO side and 1771 engraved on the other. CARDIZEM 60-mg tablets are supplied in bottles of 100 (NDC 0088-1772-47) a Dose Identification Paks of 100 (NDC 0088-1772-49). Eac tablet is engraved with MARION on one side and 1772 on t

Issued

Another patient benefit product from

PHARMACEUTICAL DIVISION
MARION LABORATORIES, INC.
KANSAS CITY, MISSOURI 64137

Medical Education of New Jersey: The Development of UMDNJ

Stanley S. Bergen, Jr., M.D., Newark*

The history of the University of Medicine and Dentistry parallels the development of health professions education in New Jersey. This article will discuss the past and present achievements of medical education in the Garden State.

The history of the University of Medicine and Dentistry of New Jersey (UMDNJ) parallels the development of health professions education New Jersey. Created to consolidate and unify all of the state's public programs in medical and dental education, UMDNJ was founded in 1970 by an act of the state legislature as the College of Medicine and Dentistry of New Jersey (UMDNJ). In 1981, it was granted status as a free-standing university, in recognition of its growth and development as a statewide system for health.

The creation of a public university fully devoted to the health sciences was a landmark in the history of the state. Throughout New Jersey's history, no school of medicine had survived to celebrate its decennial. There were several unsuccessful attempts during the 18th and 19th centuries—including two by Princeton University and three by Rutgers University—to establish such programs, but the history of health sciences education had been one of benign neglect.

An underlying barrier to the establishment of professional education programs was the attitude of the citizenry; perhaps because of the state's proximity to New York and Philadelphia with their numerous programs, New Jersey did not need its own medical and dental schools. For centuries, young New Jerseyans were sent to other states for professional education, on the assumption that sufficient numbers would return to settle and practice in the state.

By the mid-20th century, however, it was becoming increasingly clear that this strategy was not working. With 109.1 physicians in private practice per 100,000 citizens, the state already had fallen below the national average; while the ratio of 1 dentist per 1,533 persons was considered good, studies had shown that alarming numbers of practitioners in both professions were 50 years of age or older.

The state also found itself lacking many of the other benefits which are engendered by the presence of a medical school: the sophisticated specialty care programs which often are beyond the resources of community hospitals; the swift implementation of new techniques and equipment; and the initiation of research and prevention programs geared specifically to the state's needs.

In 1950, a study commissioned by Governor Alfred E. Driscoll favored a state-sponsored medical school, based on emerging trends of physician shortage and projected health needs. Among other findings, this study formally dispelled the long-standing belief that New Jersey was prohibited from having a medical education program because of antivivisection laws.

Despite the findings of the Driscoll study, no action was taken toward establishment of a program. The state's citizens were not ready to accept the concept of a publicly funded medical school. This still was dem-

*Dr. Bergen is President of UMDNJ.

onstrated clearly in 1954 when a referendum endorsed by Governor Robert B. Meyner, which would have provided $25 million for a state medical school, was rejected by the voters.

In that same year, the gauntlet was taken up by a private institution, Seton Hall University, a Catholic institution supported by the Archdiocese of Newark. Chartered in 1954, the Seton Hall College of Medicine and Dentistry, based at the Jersey City Medical Center, enrolled its first class of 80 medical and 40 dental students in 1956. A second private school, Fairleigh Dickinson University, enrolled its first class of 45 dental students in the same year. With the inauguration of these programs, many New Jerseyans were content to let the responsibility for providing the state's future health manpower rest in private hands.

This attitude was not shared, however, by Governor Meyner. In 1959, the Bane report, issued by the Surgeon General's Consultant Group on Medical Education, found that New Jersey would need two additional medical schools by 1970, just to maintain current ratios, and that the two existing dental schools would have to continue and triple their current combined enrollments. The report reinforced the Governor's belief that positive steps were needed to head off a critical shortage of health manpower in the state.

THE PLANNING YEARS: 1961 TO 1964

In 1961, Governor Meyner commissioned a feasibility study by a special faculty committee of Rutgers University. The panel, headed by the late James H. Leathem, Ph.D., who then was director of the bureau of biological research at the State University, brought forward a plan for an innovative, two-year medical program under Rutgers auspices, to be built on what now is the University's Piscataway campus.

On June 27, 1961, the plan was transformed into reality when a grant of $1,073,200 was announced by the W.K. Kellogg Foundation of Battle Creek, Michigan. Half of the grant funds were earmarked for planning and adding faculty to strengthen Rutgers existing department in the biological sciences and to set up new departments of anatomy, pathology, and pharmacology; the other half was expected to cover about one-third of the cost of a new medical sciences building.

Under plans set down by the Rutgers University faculty committee, the new school would closely integrate medical studies with graduate work in biology and the life sciences. The school would award a master of medical sciences degree, and students would transfer to other institutions for the clinical studies needed to complete the medical degree. The new school would heavily emphasize research and would weave the social sciences and the humanities into its two-year course of study.

In October 1962, DeWitt Stetten, Jr., M.D., Ph..D., was named dean of the medical school. Dr. Stetten, an eminent biochemical researcher, proved to be the school's master builder, rapidly launching planning and fundraising efforts. He also succeeded in recruiting a small but distinguished faculty, and by 1964, though it yet had no students or buildings, the school had an active research program, based in university and industrial facilities.

In December 1963, an affiliation agreement wa signed between the school and Middlesex General Hos pital, to provide for the limited clinical exposure whic would be required in the basic science program. E mid-1964, plans for a $16 million medical science com plex had been approved by the University's board governors, and the inaugural class was slated to begi studies in 1966.

THE FIRST CONFLICT: 1965

The Piscataway school's smooth progress, eagerly re ported in the state's press and hailed by physician educators, and politicians was interrupted in the fa of 1964 when the question arose of a state takeove of the Seton Hall College of Medicine and Dentistry The proposal sparked a clash that was to divide th state.

Although developing as one of the strongest youn academic institutions in the nation, Seton Hall Colleg of Medicine and Dentistry was faltering without th benefit of public support. In 1964, with a total debt o more than $7 million, the Archdiocese of Newark peti tioned the state of New Jersey to take over operation of the medical and dental school.

While the decision to continue the school under pub lic support may seem logical in view of the state' growing need, the transition did not come easily. A fact-finding committee appointed by Governor Richar J. Hughes and chaired by George F. Smith found re sistance to the proposal, particularly from the school' nearest kin, the Rutgers Medical School.

The Seton Hall complex was urban-based, having operated for ten years from the Jersey City Medica Center, with affiliations for clinical training in severa other North Jersey hospitals. And while the school did have a considerable research program, its curriculum was oriented primarily toward the clinical practice o medicine.

Dr. Stetten, however, was a research-oriented pro fessional. Although he held a variety of prestigious teaching and research posts, he had not practiced clinical medicine in a quarter of a century. In all of his public statements, he had stressed the development o curriculum with a similar leaning. In a special article for the Vineland *Times Journal* in 1963, he wrote: "Our school, like every other two-year school of recent planning, will be rich in research orientation. Opportunities will be presented not only to secure basic science medical training but also training toward the Ph.D. degree in the basic biological sciences including biochemistry, physiology, and microbiology."

The state acquisition of Seton Hall was viewed by Rutgers as a threat to its program, both financially and philosophically. State support of a second school would mean that limited tax dollars would have to be split. And the two institutions would be in competition for the same federal and private grant support, particularly if the other school were to be relocated and a new campus built for it.

It also was feared that any relationship, however remote, between the developing school and an established, clinical-oriented, community-based program would endanger the educational goals laid out for the new school. On this point, the Rutgers administration

came into direct conflict with the Medical Society of New Jersey and with many of the state's political and community leaders, who felt that New Jersey needed medical practitioners, and not scientists.

Professionals predicted that a research-oriented Rutgers Medical School would "turn into a monolithic, unyieldingly conservative institution," while lay leaders took exception to the abandonment of community hospitals and public health in favor of the laboratory.

The conflict was resolved, for the time being, by Governor Hughes, who wanted both medical schools for the state. He supported a pair of bills, one allocating $4 million for the Seton Hall takeover and a second committing $6 million to the Rutgers program. The schools were to operate separately, although it was suggested that in five years the two schools might be merged, probably under Rutgers University auspices. Rutgers also was urged to direct its planning toward a four-year program.

THE FOCUS SHIFTS: 1965 TO 1970

During the next five years, the two institutions continued to develop their programs separately. At Rutgers University Medical School, the progress was smooth and well ordered. In September 1966, a pilot class of 16 students entered the new school. Until permanent facilities could be constructed, the program was housed in facilities borrowed from the science departments at Rutgers University. A year later, in November 1967, the cornerstone was laid for the $16 million medical science building. By now, plans included a psychiatric institute and a 450-bed university hospital. Class size would remain at 16 until the new building could be completed in 1969.

The Jersey City school, renamed the New Jersey College of Medicine and Dentistry (NJCMD) was struggling for its very survival. The new public institution had to reverse the probationary accreditation status left behind by Seton Hall, and to build a strong full-time faculty, since a large percentage of its professional staff, hired under Seton Hall auspices, had been part-time and volunteer clinicians.

In addition, it soon became apparent that the school would have to be relocated. The College's trustees determined that the cost of rehabilitating the Jersey City Medical Center would be nearly as great as that of constructing a new complex. Also, the political situation in Jersey City had made the College's position untenable, with local politicians attempting to control the academic program and fill key faculty positions.

A site selection committee was formed, composed of medical educators from throughout the nation, in order to choose the best possible location for the new campus. At the same time, however, a massive campaign was launched by the city of Newark to attract the medical school, garnering support from the local press and the community's social and health care agencies.

The setting into which Newark invited the new school was a forbidding one. By the early 1960s, the city was a tinderbox waiting for a spark. The most desperate set of social, economic, and political problems ever seen in the United States had converged upon the city's populace. Newark of the 1960s was beset by crushing poverty. With the second highest population density in the nation, the city had the fifth highest rate of unemployment, and was among the lowest in per capita income and highest in crime rate. One-third of its housing was classified as substandard, the highest percentage in any city of comparable size. The city's social and financial woes were complicated further by one of the most serious health pictures in the country. It had the highest rates of venereal disease, tuberculosis, and maternal mortality; it had the seventh highest rate of drug addiction. Death rates due to accidents, lead poisoning, cancer, and heart disease also were among the highest in the nation. The city could offer its population little relief through the public health system. When the major public hospital, Newark City Hospital (established in 1882), opened its newest structure in 1954, it already was obsolete, constructed from plans for an open-ward facility, which had been drawn up in the 1930s. Even though it was a relatively new facility, the city's financial difficulties had caused it to become run-down, overcrowded, and understaffed.

As early as 1962, Newark's Mayor Hugh Addonizio recognized the potential value of a medical school in easing the city's problems. He offered Newark City Hospital to any medical school willing to take it over and run it.

For many in the academic and professional communities, the idea of building a medical school in Newark was unthinkable. Although some older educational institutions had found themselves in depressed areas during the past decade through the process of urban decay, none ever deliberately had been built in such a location. Some medical educators, both on the school's faculty and across the nation, felt that a teaching institution had no place in the health care delivery system, and that educational programs and goals would be eclipsed by the burden of providing for the community's overwhelming health needs. Furthermore, with political pressure mounting in Jersey City, many hoped to find a free and protected environment for the troubled school, in which academic programs would develop without interference or distraction.

In June 1966, the site selection committee strongly urged that the College accept the offer of a 138-acre estate of Mrs. M. Hartley Dodge in Madison. Newark, however, did not allow itself it be written off so easily. In order to present a better offer than the Madison site, city officials forwarded a plan to provide 185 acres for the new campus. According to Donald Malafronte, who was both director of the Model Cities Program and administrative assistant to the Mayor, in testimony before the Governor's Select Commission on Civil Disturbances, the city knew all along that it could not deliver such a large parcel of land: "We felt that in the end they [state officials] would come down in their demands to 20 to 30 acres in Fairmount, or that in a battle, we might have to give up some more acreage. We never felt they would ask for 185. We felt it was a ploy on their part."

According to Robert R. Cadmus, president of NJCMD, the College's board of trustees took the offer at face value. Although they had no need for such a large tract at present, they felt it was their duty to



Figure 1—UMDNJ-Rutgers Medical School, Piscataway.

provide as much flexibility as possible for future growth. Neither the trustees nor the school's administration had any idea of what clearing so much land would mean to the community. By mid-1967, the College agreed to the city's 185-acre offer.

Black Newark residents, however, had their own view of the medical school plan. They saw the College as a greedy invader, taking away their homes and land, and returning nothing to the community. The black community had no clear-cut leadership, and as a result, many different interest groups took advantage of the community's anger over the medical school to promote interest in the city's other pressing problems. As a result of issues such as poor housing, unemployment, inadequate education, and job discrimination, violence erupted, and Newark rioted. In the eruption, the medical school nearly was lost. With the perceived danger from shootings and fires added to their objections, many faculty members resigned. Students and medical residents, convinced that they were being used as pawns in some political game and that their future careers were being jeopardized, pressed for transfers to other institutions. The school narrowly missed being disbanded and its charter relinquished by a vote of its faculty.

On the other hand, the state of New Jersey and Governor Hughes believed that the medical school had a valid contribution to make in Newark. The situation warranted new and extraordinary measures, and the state sat down with the community and negotiated a site for its medical school.

The ensuing discussions clarified what the community wanted, what the College planned, and how the two sets of goals could be unified. The result was the Newark Agreements of 1968, a social contract which, perhaps, was unprecedented in the history of medical education.

Under the terms of this agreement, NJCMD agreed to accept primary responsibility for health care delivery in Newark. In the past, the services offered by a medical school extended only as far as its curricular needs. But the College agreed to assume the role of "family physician" to New Jersey's most medically underserved population. In education, the College vowed to undertake special efforts to step up the recruitment of minority students into its own programs, as well as to develop programs in the allied health professions and "career-ladder" training for its future employees.

With the signing of the Newark Agreements, tl medical school's future was secure. In 1967, it r located to Newark. On July 1, 1968, Newark City Hosp tal was acquired by the state for one dollar and r named the Martland Medical Unit of NJCMD in hon of the noted Newark pathologist, Harrison Stanfo Martland, M.D.

A NEW BEGINNING: 1970

Although the early experience of the medical scho in Newark had been a painful one, the concepts social commitment and active participation in healt care delivery brought forward by the controversy mac a profound impact upon the thinking of New Jersey decision makers. The state's health care needs we growing more acute throughout the period, and publ and governmental concern about current and futu problems was increasing. By 1970, there were mar who felt that the "radical" concept applied in Newar should become a statewide model.

On May 4, 1970, in a special message, "Educatio for Better Medical Care," Governor William Cahill e pressed his concerns for the health professions educa tion system to members of the State Senate and Ge eral Assembly: "New Jersey today needs a re-evaluatio of policy and a renewed commitment to medical educa tion. We have ... reached a point ... when the implica tions of past decisions can no longer be pushed aside

The Governor and the legislature also felt that it wa too late in terms of the state's health problems to d velop traditional medical and dental schools and hop that they would yield a sufficient increase in pract tioners. It was felt that since the state was more or les starting from scratch, there was an opportunity to tak more positive action with its health professions educa tion system.

"New Jersey had the opportunity, and must, for it own health survival, insist upon that form of medica education which considers the entire medical needs the state," Governor Cahill said. "While the prime bus ness of medical educators is obviously education, th way in which they carry out their mission must b related to the total community." The Governor e pressed concern, however, regarding the overwhelmin costs of health professions education, and the mos reasonable way in which such a burden could be born by the state. He feared that two separate institution competing for the same limited state and federal fund might not serve the best interests of the state, an called for legislation to combine the two units unde a single board of trustees: "A single administrativ entity will be able to advise me on problems of capita funding for medical education from a statewide per spective and with expertise."

Instead of placing the state's health professions re sources under Rutgers University aegis as had beer anticipated in 1966, Governor Cahill moved for th creation of a freestanding health sciences universit charged with a dual mission. The College of Medicin and Dentistry of New Jersey (CMDNJ) was to be re sponsible for coordination and leadership of healt professions education for the state. At the same time it was to coordinate a system of health services to fi

entified gaps through its own base facilities as well through cooperation with hospitals and other alth resources statewide.

The financial and philosophical implications of this gislation were too unpalatable for Dr. Stetten. As on as the bill became law, he resigned his post at utgers Medical School, as did a number of other fac- ty members. The remainder of the CMDNJ-Rutgers edical School faculty nervously accepted its new entity, and was to remain ambivalent in its attitude ward the new institution throughout the early 970s.

The fear in Piscataway was that the overwhelming eds of its Newark-based counterpart and the huge nstruction planned would relegate its development a secondary position.

In Newark, meanwhile, the CMDNJ-New Jersey Medi- l School's administration, faculty, and student body gorously supported the Governor's plan and testified fore the legislation on behalf of his proposals. It was lt that a statewide system would emphasize academic uality and would help with the local problems which ad engulfed the Newark campus.

UIDELINES FOR GROWTH: 1970 TO 1979

From its very inception, CMDNJ enjoyed a good easure of willing and enthusiastic support from the ate—through its governmental leaders, its pro- ssional communities, and the public at large. A new oard of trustees was appointed by the Governor, awing capable and dedicated individuals from busi- ss and the professions, headed by John K. Kittredge, senior vice-president of Prudential Insurance Com- uny of America. With its new optimistic leadership in ace, CMDNJ quickly crystallized its priorities for owth during its first decade. Its efforts would focus three major areas simultaneously, each in itself a rculean task: construction of a new, $200 million mpus in Newark, and expansion and improvement both health care and teaching programs; develop- ent of the clinical teaching programs at CMDNJ- utgers Medical School which would permit it to be- me a full, four-year program and to augment health rvices in central New Jersey; and development of a edical education program in southern New Jersey.

HE GROWTH YEARS: NEWARK

Throughout the 1970s, the history of CMDNJ New- k was one of building, growing, and improving ser- ces. In 1971, the College broke ground for its $200- illion campus on a 46-acre site in Newark's central ard. The campus, one of the largest building pro- ams ever undertaken by a health sciences institu- on, was dedicated on May 10, 1976, a date which has nce been observed as Health Education Day in New rsey.

The campus is the site of four of the University's six hools: UMDNJ-New Jersey Medical School, and MDNJ-New Jersey Dental School (which are continu- ions of programs which began under Seton Hall), MDNJ-Graduate School of Biomedical Sciences hich became a school of the College in 1969), and e UMDNJ-School of Health-Related Professions (es- blished in 1976).



Figure 2—UMDNJ-Newark campus.

In health care delivery, the University's presence has had a dramatic impact upon Newark. During the first decade, a coalition of College, state, city, and federal health programs participated in creating statistics such as a 50 percent decrease in infant mortality, a 60 percent reduction in tuberculosis deaths, and 50 percent decrease in the cancer death rate, as well as significant drops due to bronchial pneumonia and heart disease.

Under the original plans developed in 1968, the medical school had originally determined to maintain Martland as a primary care facility, with a new 272-bed tertiary care referral hospital to be built on the new campus to supplement it. On the advice of the community, and particularly of Newark's Mayor Kenneth A. Gibson, the CMDNJ Board of Trustees reconsidered the plan.

In 1972, the Board voted to have plans for the Newark campus redesigned, to incorporate a single, 520-bed facility. UMDNJ-University Hospital, the final phase of the Newark construction program, was opened in 1979, further enhancing the University's ability to expand the scope of its services and the quality of care it can offer.

THE GROWTH YEARS: PISCATAWAY

Despite the faculty's initial misgivings, the newly-formed CMDNJ moved rapidly to expand its central New Jersey program.

Before the end of 1970, the opening of the new medical science building on the Piscataway campus had allowed expansion of the entering class from 16 to 80 students. In addition, plans were finalized for the 80-bed Institute of Mental Health Sciences, which would open in 1972. The Raritan Valley Hospital, Green Brook, was acquired as a teaching facility, allowing the development of a full, four-year program. A construction program at the hospital soon was undertaken to add an ambulatory care wing, completed in 1973.

For most of the first decade, development at the Piscataway school centered around the question of a teaching hospital and full enrollment in the medical degree program. From the beginning, Raritan Valley was viewed as a temporary or partial solution, since it was clear that the 131-bed facility never could accommodate the full entering class, which would level off at 108 by 1973.

The acquisition of Raritan Valley did allow, however, beginnings of a medical degree program. By 1972, the first third-year class of 32 students was enrolled, allowing for the school to award its first medical degrees in 1974. Third-year enrollment was expanded to 56 the following year, where it would remain until additional clinical facilities were acquired. In the meantime, though, nearly half of each entering class had to leave the state to complete their degrees.

In 1971, Governor Cahill had promised to build a 325-bed university hospital adjacent to the medical school in Piscataway. Two years later, Governor Brendan T. Byrne reduced the plan to a 181-bed tertiary care center, citing issues such as cost containment, too many hospital beds in the area, and effective utilization of resources, By 1974, architectural plans for this unit had been developed and the state had issued bonds to finance its construction. But the bond issue was not placed for sale, and plans for the hospital remained in limbo.

The history of UMDNJ parallels the development of health professions education.

The status of the on-campus hospital remained unclarified, and in January 1976, a special committee was appointed to consider functional alternatives to a construction program. The search led eventually to Middlesex General Hospital, New Brunswick, partly as a reaffirmation of the College's commitment to the state's underserved urban centers. Negotiations were opened with the 364-bed facility, resulting in an expanded affiliation agreement, signed on November 23, 1977, which designated it as the school's core teaching hospital.

The additional resources and space provided by the union with the hospital, which recently changed its name to Middlesex General-University Hospital, have allowed the third- and fourth-year classes to reach full size.

THE GROWTH YEARS: SOUTH JERSEY

The idea of a medical education program in southern New Jersey was first advanced by Governor Hughes in 1965. As he signed into law the bill by which the Seton Hall College of Medicine and Dentistry became the state's second public program in the health sciences, he predicted that New Jersey would soon have "a third medical school, this one in southern New Jersey."

For the time being, however, the financial pressures of developing two health sciences campuses proved to be enough for the state. Seven years passed and another governor was in office before the concept was brought forward again. It took seven more years, and yet another administration, before the first medical students actually began training in south Jersey.

In 1971, with the beginning of progress already in evidence at the Newark and Piscataway campuses, Governor Cahill felt that the time had come for CMDNJ to explore the question of taking its mission statewic He directed CMDNJ through the Department of High Education to develop a feasibility study concerning t creation of a medical school in south Jersey. The 1 month investigation included an extensive series meetings with hospitals, medical and osteopathic c ganizations, state, local, and federal accrediting age cies, and other interested parties.

The report, presented to the Governor in May 197 clearly established the need for a medical educatic program serving the seven-county southern region. showed that southern New Jersey already had a ph sician-to-population ratio considerably lower than t state and national average, and that an alarmi number of those currently in practice were 50 yea of age and older. It was determined that there wou be a shortage of at least 100 physicians a year in t area by 1980. Other problems related to physicia supply which were indicated included poor geograph distribution, decreasing numbers of practitioners the primary care disciplines, and extensive d pendence upon foreign medical graduates. The repo noted serious health trends developing in south Jers and pointed out CMDNJ's potential ability to help r verse the steadily worsening statistics.

The plan advanced by CMDNJ was for a medic "school without walls." This term described a progra which would conduct its clinical education in existir community hospitals, rather than undertaking co struction of a new teaching facility. The concept, whic later was employed very successfully by the UMDN Rutgers Medical School, was designed to save the sta money and to strengthen ties with local resources ar professionals.

The idea of an osteopathic component for the sou Jersey program was raised from the outset of the pla ning process, in the interests of the best utilization local resources. Two of the largest and best equipp hospitals in the region were osteopathic hospita Moreover, a large percentage of the area's practicir physicians, particularly in the primary care specialtie were D.O.s.

Originally, the College had wished to establish single program with a unified faculty with option tracks which would allow students to choose to pursu either the M.D. degree or the D.O. degree. Althoug preliminary discussions showed both professions r sistant to such a plan, CMDNJ believed that it wou be appropriate for the College to take a leadership ro in such an innovative venture, aimed at cementir relations and enhancing communications between t two branches of medicine.

Later, to meet accreditation requirements and t qualify for federal funds. the program changed for A new school, the CMDNJ-New Jersey School of O teopathic Medicine, would be founded, in addition t an allopathic (M.D.) program, the CMDNJ-South Jerse Medical Education Program, which would be an e tension of the Newark and Piscataway programs.

In 1975, Governor Brendan Bryne signed the Ne Jersey legislature's bill 1540, which directed CMDN to establish, develop, and operate both osteopathic an allopathic educational programs in south Jersey b 1976. The College accelerated its efforts to implemer its dual program.

The allopathic educational program was developed s a satellite campus of CMDNJ-Rutgers Medical chool, in which students would take their first two ears at the Newark medical school, and then under- ake the clinical portion of their education in south ersey hospitals. Cooper Medical Center, Camden, was dentified as the core teaching hospital for the pro- ram in 1977, becoming CMDNJ's first affiliated hos- ital in south Jersey.

A pilot group of 12 students undertook clinical train- ng at Cooper Medical Center in 1978. The first full lass of UMDNJ-Rutgers Medical School at Camden egan studies in Newark in 1981, and entered their ird-year clinical classes at the Camden facility, now alled Cooper Hospital-University Medical Center, in 983. Ultimately, the allopathic program will have 96 ird- and fourth-year students based in Camden.

UMDNJ-School of Osteopathic Medicine became a rmal school in December 1976. In order to bring the ew school into operations as quickly as possible a lan was devised in which osteopathic students tem- orarily would receive basic sciences education at MDNJ-Rutgers Medical School, and take clinical training at John F. Kennedy Memorial Hospital, Stratford, which became its primary teaching affiliate in 1977. Its first class of D.O. candidates were enrolled in September 1977, and began clinical training at John Kennedy Memorial Hospital (now Kennedy Memorial Hospital/University Medical Center) in September 1979.

CONCLUSION

The achievement of University status in 1981 came at a turning point in UMDNJ's development (Figures 1 and 2). During the first decade, the institution virtually had met its enrollment goals and built its campuses, often with limited resources and less-than-perfect conditions. It had created innovative solutions to meet the commitments set upon it by its local communities, the state, and the higher education system. It had helped to maximize utilization of New Jersey's resources by forming cooperative programs with other educational facilities, and by affiliating with community hospitals to utilize, rather than to duplicate, existing health care programs.

The First 40 Years of Osteopathic Medicine in New Jersey

Robert L. Thompson, Ed.D., and Christine Chico, D.O., Piscataway*

This essay sketches the story of the first 40 years of osteopathic medicine in New Jersey, from 1900 to 1940. This account discusses the fight for legal recognition and the right to practice.

Andrew Taylor Still, a frontier physician and former surgeon in the Kansas militia during the Civil War, was the founder of "osteopathy," a major reform movement in American medicine. Still dated his new approach to the treatment of disease to June 22, 1874, when he abandoned traditional medical practice in favor of osteopathy which rejected the use of drugs and emphasized the importance of the unimpaired function of the musculoskeletal system nourished by healthy vascular and nervous systems. Osteopathic treatment consisted of the use of palpatory diagnosis to identify the location and extent of the "osteopathic lesion," the source of the patient's complaint, normally followed by manipulative procedures to treat the affected area or part. Good nutritional practices, proper rest, and exercise were prescribed; the use of tobacco and alcohol were discouraged and often forbidden, particularly by Still himself.[3] After an itinerant career in the Kansas-Missouri area, Still settled in Kirksville, Missouri, where he opened his American School of Osteopathy in 1892. The first course of study was only 9 months long.[4] In 1894, the state chartered his school which authorized Still to award a professional degree. Although the School undoubtedly was permitted to confer the M.D. degree, Still chose "Diplomate in Osteopathy" which later was changed to "Doctor of Osteopathy;" the D.O. degree conferred to this day. Still's original school and imitations which sprang up immediately had no for mal educational requirements for entrance, a situatio which was to cause significant difficulty for the D.O.' in their attempts to obtain legal and professional rec ognition including those D.O.'s in New Jersey. By 190(the curriculum had expanded to two years and 1{ months, by mandate of the Associated Colleges of Os teopathy and to a compulsory three years and 2' months program in 1904 by direction of the Americai Osteopathic Association, founded in 1901.[1]

According to anecdotal reports, osteopaths firs practiced in New Jersey in 1897 to 1898. It is no surprising that the first published response to th(arrival of these new drugless practitioners appeared ir the *Transactions* of the Medical Society of New Jersey and *The Journal*, MSNJ. In the reports for the distric societies, E.L.B. Godfrey, M.D., of Camden, presented a warning in 1899 entitled "Osteopathy" which he calle("The latest of these fraudulent systems to attain th(proportions of a popular fad ... in comparison with which the other 'pathies' shine as radiant stars."[5] Dr Godfrey further declared that the claims that os teopathy did not come under the provisions of th(Medical Practice Act of 1890 were false. The 1899 re

*Dr. Thompson is Associate Dean for Student Affairs an(Admissions and Adjunct Associate Professor, Osteopathi Sciences, UMDNJ-School of Osteopathic Medicine Piscataway; and Dr. Chico is an Intern, Dallas Memorial Hos pital, Texas.

ort of the State Board of Medical Examiners also oted the situation: "Section IV. The Present Medical aw. There are but few medical graduates of reputable nedical colleges who attempt to evade the law. More ifficulty is experienced with fraudulent practitioners ho practice medicine in violation of the law while aiming technical exemption from its provisions, the hief of whom are Christian Scientists and os-opaths." In spite of this hostile professional climate, ne D.O.'s soon let it be known that they intended to emain.

In the first of two articles, Harry Linden Chiles, D.O., f Essex County, recalled that "a dozen osteopaths, ractically all of the recognized osteopaths in the tates" met in Newark on October 17, 1901, and or-anized the New Jersey Osteopathic Society (NJOS).[7] n November 1902, the members of NJOS convened in renton to legally establish their group; the articles of ncorporation for the Society are dated April 18, 1903. he present name of the organization, New Jersey As-ociation of Osteopathic Physicians and Surgeons NJAOPS) was adopted on May 8, 1948. As Chiles re-orted: "The organization of the State Society followed y its incorporation seemed to be accepted by the nedical organization [The Medical Society of New Jer-ey] as notice that the osteopaths intended to stay and roaden as a profession."[7] On December 6, 1902, the nembers of NJOS met in Newark to consider the first f many bills to come which were presented to the egislature to provide for the licensing of osteopaths nd the establishment of a separate board of os-eopathic examiners to oversee the profession.[7]

THE FIRST LICENSING ACT—1913

In 1905, a bill proposed by the newly organized os-eopaths providing for a separate board of osteopathic xaminers died in committee hearings. A substitute ill offered by the Medical Society placing the D.O.'s nder the State Board of Medical Examiners with os-eopathic representation similarly failed.

During the administration of Governor J. Franklin ort in 1910, the medical community proposed an mendment to the Medical Practice Act raising reliminary educational requirements for physicians hich would have excluded most osteopaths then in ractice from qualifying for licensure under any subse-uent legislation.[7] During a public hearing on the bill, Governor Fort had an acrimonious exchange with Dr. uther Halsey representing the Medical Society over he Governor's campaign promises to the medical pro-ession to support high educational standards for hysicians. The Governor called Dr. Halsey a "liar" and he incident was reported by the press. Governor Fort etoed the bill which had passed both houses of the egislature. At their Annual Meeting a few weeks later, he Medical Society recorded "His actions have re-ulted in lowering the standards of preliminary educa-ional requirements in New Jersey and the consequent oss of reciprocity between our state and the state of New York."[8] The Governor later invited several New Jersey D.O.'s to be among the medical guests at a re-eption at the Summer White House in Long Branch or General Leonard Wood; Chiles noted that this ac-ion was a significant mark of recognition for the pro-ession.[7]

In 1913, the members of NJOS, 120 strong, were unable to successfully oppose a bill to amend the Medical Practice Act similar to the proposed measures of 1905 which placed the authority to license osteopaths under the State Board of Medical Examiners. An influential group of "irregular" osteopaths, those D.O.'s who had graduated from an osteopathic school unapproved by the AOA, who were not members of NJOS sided with members of the Medical Society in support of a joint M.D.-D.O. board of examiners. At a meeting of NJOS on March 19, 1913, the members agreed that it was useless to oppose further the offensive bill which passed the legislature on April 2, and signed into law. Dr. D. Webb Granberry, president of NJOS, was selected to be the first osteopathic representative on the State Board of Medical Examiners.[7]

The *Registry of Osteopathy* in the office of the New Jersey State Board of Medical Examiners, Trenton, contains the names and the required personal and educational information about the first 113 D.O.'s who presented credentials certifying to their personal attendance and graduation from a regularly organized school of osteopathy. Each of these D.O.'s was "registered" on April 12, 1913, and given a license to file with the clerk of the court in the county where he resided. Thirty-four percent of this original number were women. Many of the "irregular" osteopaths presented credentials to the Board in order to be registered. Dr. Granberry recommended rejection of most of these applicants. His recommendations were sustained by the Board but the disappointed "irregulars" sued the Board to obtain their licenses. The compromise solution required the applicants to take additional instruction. The process of litigation, however, brought embarrassing publicity to the D.O.'s concerning the short-lived New Jersey College of Osteopathy in Passaic (1906 to 1910) where diplomas were issued for little or no attendance.

What did the osteopaths receive in this legislation? They received a license to practice "osteopathy" which forbade them from prescribing or administering any drugs or medications and the performance of any surgery "which required a cutting edge." They were permitted to practice obstetrics, but were not permitted to relieve the pain of childbirth with analgesics; they were authorized to sign birth certificates and death certificates, but were forbidden to perform any emergency surgery which might have saved a life. In addition, they were required to observe the same procedures as M.D.'s in reporting contagious diseases. According to the new licensing act, D.O.'s would take the same examinations as M.D. candidates with the exception of drug therapeutics being examined instead of osteopathic principles and practices. They were limited by the new law to the use of manipulative osteopathic treatments although they considered themselves to be complete physicians. As Helminski reported, the first state practice laws which established the rights of osteopaths denied them identification as complete physicians and served to establish them instead as practitioners who were legally limited to the use of manipulative procedures.[9] This "status inconsistency" has confused the public as to the place of the osteopathic physician in the hierarchy of health care professionals.[1]

No account of medical history of this period can omit a reference to the critical analysis made of medical education by Abraham Flexner in 1909 to 1910 on behalf of the Carnegie Foundation for the Advancement of Teaching. He ridiculed the pretensions of the osteopathic colleges toward any scientific medical education, but recognized that they were well-run businesses.[10] The osteopathic schools always playing catch-up ball did not need the Flexner Report to encourage them; the years following his report marked the beginnings of a vigorous curriculum expansion in both the basic and clinical sciences.

CURRICULUM REFORM AND EDUCATIONAL STANDARDS

The period between the first osteopathic licensing act in 1913 and the achievement of unlimited practice rights in New Jersey in 1935 was marked by two important developments: the evolution of the curriculum in the D.O. schools and the impetus to improve the general educational standards of the profession.[1]

There was no instruction in drug therapeutics in the curriculum of the early osteopathic schools. This void caused difficulties for the D.O. applicant for licensure in states with a joint M.D.-D.O. board of medical examiners such as New Jersey. Although the D.O.'s were not examined in materia medica, there were questions about drug therapeutics on other sections of the examinations. The "lesionists" D.O.'s insisted upon restricting osteopathic practice hence osteopathic instruction to manipulative procedures and drugless adjuncts such as diet and exercise. The "broad" osteopaths wished to be able to employ some of the more common drugs including analgesics. The American Osteopathic Association did not agree to permit the inclusion of pharmacology or drug therapeutics in the curricula of the osteopathic schools until 1929.

The lack of uniform educational standards for admission to the osteopathic schools was another major sticking point whenever D.O.'s pressed for a liberalization of state medical practice arts. The AOA did not stipulate that the completion of a high school education was necessary for entrance until 1920. During the 1921 session of the New Jersey legislature, two bills were introduced concerning the regulation of osteopathic medicine. One bill called for the creation of a new board of examiners to regulate drugless practitioners; the bill failed chiefly because members of the regular medical establishment were committed to maintaining the licensing authority for all health professionals under the jurisdiction of a composite board of examiners.[11] The more difficult bill proposed much higher educational standards for osteopaths. The measure would require all applicants for a license to have completed private or public high school and one year of preprofessional education at the college level before entering an osteopathic school. The bill also called for an increase to two years of premedical studies by 1925. In addition, it was proposed that the D.O. applicant complete a one-year intensive postgraduate program in surgery at an osteopathic college. A special examination then was to be required in surgery. The successful licensee then would be empowered to practice as an osteopathic physician and surgeon. The fact that there were no hospitals in New Jersey in which a D.O. could perform surgery was a significant fact in the total movement by New Jersey D.O.'s to establi their own institutions. After the bill had failed, t president of NJAOPS suggested that the high standards proposed for D.O.'s had nothing to do wi greater protection for the public, but was in fact a mo to reduce professional competition.[11] The osteopath profession in New Jersey as elsewhere continued gain a public following, but incidents such as the di missal in February 1928, of Dr. James E. Chastney Hasbrouck Heights as the local school physician on t grounds that he was not qualified by law to ser exemplified some of the professional discord whi existed and kept the public confused about the stat of the osteopath.[11]

The postwar period opened a new horizon for the osteopath.

In 1929, the osteopaths again mounted a major cam paign to gain more favorable practice rights. The NJO supported Senate 44 which would have required tw years of premed education and a two-year internshi for D.O.'s who wished to practice obstetrics and su gery without restriction. This measure died in commit tee.

Although educational standards were bein tightened by both D.O. and M.D. schools, the *Minute* of the State Board of Medical Examiners for Novembe 18, 1926, contain instructions to the secretary to writ to the osteopathic colleges concerning the admissio of students who have not completed high school. B the end of the 1920s, the osteopathic profession ha confronted and dealt with the problem of curriculun reform, particularly the introduction of drug thera peutics and educational standards had been raised The six colleges of osteopathy were graduating on th average a total of 350 new D.O.'s annually.[1]

THE GOAL IS REACHED

The decade of the 1930s did not begin on a felicitous note. *The Bulletin* of NJAOPS for January 1930, re ported that one D.O. had been arrested weekly since Christmas for practicing beyond the limit of the license. In a special mailing, NJAOPS warned its mem bers to avoid writing prescriptions, administering drugs, or giving irrigations. These embarrassments did not concern the osteopaths who scrupulously prac ticed "ten-fingered osteopathy" within the law, but they were symbolic of a basic inconsistency between the D.O.'s education as a complete physician and the restrictions of an out-of-date medical practice law. Just when the profession needed them the most, a particularly talented and dedicated group of leaders emerged at NJAOPS who combined political astuteness with organizational skills. From 1932 until the passage of the new medical practice act in 1935, these leaders directed an unrelenting campaign to achieve full practice rights for the profession.

In September 1932, NJAOPS was ready to begin the gislative battle again. The members were informed by r. O. J. Snyder, dean of the Philadelphia College of steopathy, at their monthly meeting that if they ought the "status and dignity of licensed physicians n a parity with the medical doctor, you must first ecure legislation that will vest in you like authority nder the law."[12] On February 27, 1933, the Senate ajority Leader Clifford R. Powell introduced Senate 26 which included expanded practice rights and an ndependent board of examiners for the D.O.'s. By the ear's end no progress had been made because of "per-onal political ambitions and cliques in Trenton." In ebruary 1934, NJAOPS president John T. Atkinson of ontclair reported that the "medical machine" was tting finishing touches on a bill which would greatly estrict the osteopaths then in practice and make it mpossible for new D.O.'s to enter the state. By March, he D.O.'s bill of the previous year was introduced as enate 73 and the M.D.'s brought in Senate 183. The edical bill proposed to deny the use of the titles "Dr."; Doctor"; "Physician"; and "Surgeon" to all but doctors f medicine or dentists. Any other practitioner found sing the forbidden designations on business cards, tterheads, or office signs would be punished by a 200 fine for the first offense.[12] The bill was so ex-raordinarily punitive that it failed.

The last *Bulletin* of the Association is dated March 935. Chairman English appealed to as many D.O.'s nd friends of osteopathy as possible to crowd the halls f the General Assembly in Trenton when the new Iedical Practice Act came up for a vote. On May 6, a nuch revised bill which was the result of hours of onferences between the D.O.'s and M.D.'s passed the ssembly 44 to 1; on May 24 Governor Hoffman signed he legislation which would admit D.O.'s by examin-tion for licensure to the unlimited practice of medi-ine and surgery.[12] The bill provided that D.O.'s and I.D.'s would have to meet the same premedical and rofessional educational requirements to qualify for a cense after November 1, 1941; another clause stipu-ted that no further licenses to practice "osteopathy" ould be issued after July 1, 1939. On that date an ra in the history of medicine in New Jersey would ome to an end.

AFTERMATH

The law specified that osteopaths currently practicing would be required to complete a two-year postgraduate course in order to qualify for an unlimited license. At the end of the course they were to be examined in surgery and medical therapeutics.

With a tremendous struggle finished, NJOS began to build the Association's membership rolls. In 1936, a count of D.O.'s in New Jersey showed a total of 319 of whom 163 belonged to the NJOS. When World War II arrived, New Jersey D.O.'s like osteopathic physicians nationwide found themselves disqualified for federal service because they were not graduates of a "Class A" medical school. They became by default the health providers to a large number of the civilian population and demonstrated their contribution was more significant than might ever have been imagined. Consequently, the postwar period opened up a whole new horizon for the osteopath which still is being realized today.

REFERENCES

1. Gevitz N: *The D.O.'s: Osteopathic Medicine in America.* Baltimore, MD, The John Hopkins University Press, 1982.
2. Booth ER: *History of Osteopathy and Twentieth-Century Medical Practice.* Cincinnati, OH, The Caxton Press, 1924.
3. Still AT: *The Autobiography of Andrew Taylor Still.* Kirksville, MO, 1908, pp. 112-117.
4. Hildreth AG: *The Lengthening Shadow of Andrew Taylor Still.* Kirksville, MO, 1942, p. 39.
5. Godfrey ELB: Osteopathy. *Trans Med Soc NJ,* 1899, p. 322.
6. *Ninth Annual Report of the State Board of Medical Examiners, 1899.* Trenton, NJ, MacCrellish and Quigley. State Printers, 1900.
7. Chiles HL: The Establishment of Osteopathic Practice in New Jersey, Part I. *Bulletin NJ Osteopathic Soc* 39:5-6, 1941.
8. Rogers FB, Sayre AR: *The Healing Art: A History of the Medical Society of New Jersey.* Trenton, NJ, The Medical Society of New Jersey, 1966, p. 189.
9. Helminski F: That Peculiar Science: Osteopathic Medicine and the Law. *Law Med* 32-37, 1984.
10. Flexner A: *Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching.* Boston, MA, The Merrymount Press, 1910, pp. 62-67.
11. *Newark Evening News,* March 5, 1921; October 6, 1921; March 1, 1928; May 24, 1935.
12. *The Bulletin,* October 1932; March 1934.

The History of the New Jersey Hospital Association

Linda Staab, Princeton*

In 1918, hospital executives saw the need for an organization to promote the concerns of the health care industry and to solve common problems. Hence, the New Jersey Hospital Association was born.

On January 11, 1863, St. Mary Hospital, Hoboken, was founded by four Franciscan Sisters of the Poor from Germany. In 1864, the same order sent three additional nuns from Germany to found St. Francis Hospital, Jersey City. Women from six Protestant Episcopal churches in Newark in 1865 founded Saint Barnabas Medical Center, staffed completely by volunteers. (Now located in Livingston, Saint Barnabas Medical Center no longer is associated with a religious denomination.) By the end of the decade, eight more hospitals had been established: Jersey City Charity Hospital (its forerunner was the Pest House, founded in 1805 and used to quarantine those with infectious diseases); Saint Michael's Medical Center, Newark; the Asylum for Essex County Incurables; the New Jersey Lunatic Asylum, Trenton; St. Joseph's Hospital and Medical Center, Paterson; German Hospital; Hospital of the Ladies Association; and St. Peter's Medical Center, New Brunswick.

This, then, was the genesis of civilian hospital history in New Jersey, and institutions continued to be established to provide care within the state.

NEW JERSEY HOSPITAL ASSOCIATION

By 1918, seven hospital executives saw the need for an organization to promote the concerns of the health care industry and to find solutions to common problems. The executives met at Newark City Hospital and established the New Jersey Hospital Associatic (NJHA). Hospitals represented were Muhlenberg Ho pital, Plainfield; Elizabeth General Hospital; Hudsc Tuberculosis Hospital and Sanitarium, Secaucus; Mc ristown Hospital; Paterson General Hospital; Chri Hospital, Jersey City; and Newark City Hospital.

Following that first gathering in 1918, meetings the Association were held for several years. Questior of how hospitals managed their affairs and the sharir of information on operational issues lay at the base regular meetings; but, "before the ease of automobi transportation, it was difficult to attract membe from all parts of the state to the meetings (so)... th Association lay dormant for a period."

THE 1920s AND 1930s

The 1920s were a growing time for the New Jerse Hospital Association. NJHA now was strong enough t host two of the American Hospital Association's ar nual conventions in Atlantic City—one in 1926 an one in 1929. Then, with just 63 days remaining in th decade, the stock market crash had begun. The D pression enshrouded the United States and much c the world. In the decade that followed, unemploymer reached 12 million, Congress passed the Social Secu ity Act, and labor unions won their first major cor

*Ms. Staab is Assistant Director, Public Relations, New Jerse Hospital Association.

tracts from the automotive and steel industries. In New Jersey, efforts were underway to increase access to hospital care for the middle class and the poor. An event of lasting significance was the establishment in 1932 of the Hospital Service Plan of New Jesey (Blue Cross). The Service Plan was organized by the cooperative effort of 17 New Jersey hospitals, with the hospitals agreeing to accept flat rate payment of $6 per diem.

Between 1931 and 1936, the New Jersey Emergency Relief Administration payments exceeded $6 million for support of general health services, more than $2 million of which went directly to hospitals for the care of indigent patients.

THE 1940s

During the 1940s, hospitals continued their battle to find ways to provide adequate care for indigent patients. Following an extensive study, the NJHA Welfare Committee in 1945 recommended that legal responsibilities for providing good hospital care for the indigent be defined more clearly, that public authorities recognize that the indigent were entitled to a high standard of care, and that payment to hospitals be commensurate with the services rendered so that a hospital's financial status would not be jeopardized.

In the latter 1940s, returning soldiers flooded the nation and the wounded crowded hospitals, increasing the demand for nurses. A 1948 NJHA survey showed that ten hospitals in the state closed a total of 321 beds due to the lack of nurses. In response to the shortage, NJHA began preparing a report on "Recommended Minimum Standards for Salaries and Personnel Practices of Institutional Staff Nurses." On the national level, Congress reacted to the enhanced expectations of returning veterans by passing the Hill-Burton Act. The act, created to aid hospital construction and modernization, provided hospitals with low-interest construction loans in exchange for pledges to absorb a percentage of charity cases. Most New Jersey hospitals received grants from this program during the 1950s and 1960s.

NJHA also was experiencing changes and growth: in 1947, Harold Johnston was hired as the first full-time executive secretary (now the office of the president). In addition, NJHA formed the Middle Atlantic Hospital Conference (forerunner of the present Middle Atlantic Health Congress) with the New York and Pennsylvania Hospital Associations.

THE 1950s AND 1960s

In the 1950s, transportation and communication leaped forward; the urban population began the transition to the suburban population, reversing the trend which helped make the expansion of hospital development possible in the first half of the century. The cities developed "inner cities." Money began to flow to the suburbs, leaving inner city hospitals to cope with a high percentage of indigent patients. Additionally, the hi-tech push into space commenced, adding momentum to the technological advances occurring in hospitals and necessitating additional skills and continuing education for health care practitioners. Reflecting the growth, the Hospital Association purchased, for $18,500, its headquarters building in Trenton, remaining there until relocating to Princeton in the 1960s.

NJHA continued to be involved with the concerns of the nursing profession. During this time, NJHA assisted in revisions to the Nurses Practice Act. The involvement established NJHA as the official consultant to the Board of Nursing on matters of curriculum for schools of nursing.

The relationship with another group—unions—also drew NJHA's attention. In 1950, when unions attempted to solicit hospital employees, court decisions held that because hospitals were classified as charitable organizations and not as industries, unions had no legal right to demand collective bargaining. By 1958, however, the situation was changing, and the Association developed a series of institutes stressing the positive aspects of labor-management relations. By 1960, NJHA had commissioned landmark studies of labor relations in hospitals. In 1966 to 1967, in the landmark Christ Hospital case, the U.S. Supreme Court declared that New Jersey hospitals were not to be considered exempt from labor unionization attempts.

In the 1960s, reimbursement and planning became targets for action by NJHA.

In 1963, Jack Owen took over and was to lead the Association for 19 years.

The passage of Medicare and Medicaid in the 1960s mitigated the problem of providing health care for those unable to pay. But the relief was only partial and those hospitals with severe indigency problems began to stagger under the financial burden. Solutions were still to be found.

Early in 1964, NJHA founded the Hospital Research and Educational Trust of New Jersey to study ways in which "men, money, and materials can be more effectively used in the hospital operation, and to study new concepts in health care." The next year saw the establishment of the NJHA Insurance Fund, a group insurance program for hospital employees.

Two complicated issues—reimbursement and planning—became targets for action by hospitals in the Garden State. A voluntary health planning mechanism was developed in the mid-1960s under the aegis of NJHA. It became the independent, nonprofit Health Facilities Planning Council, functioning under a Board of Trustees with regional committees representing various sections of the state.

Local planning committees were established in each section to review hospital projects and provide recommendations to a statewide board.

As for reimbursement, in 1968, 15 hospitals began a voluntary budget review process, subjecting their budgets to the Hospital Research and Educational Trust. This was just the beginning of a long and very complex trail.

THE 1970s

During the 1970s, a federal health planning program supplanted New Jersey's voluntary planning program. Under the federal program, New Jersey was divided into regional planning areas in which five Health Systems Agencies presently function. The governing boards of these agencies are composed of volunteers and include at least 51 percent consumer representation.

In 1971, the state legislature enacted the Health Facilities Planning Act which created the Health Care Administration Board (HCAB), and certificate-of-need controls on hospital capital projects. The Hospital Association assisted hospitals in applying for certificates of need and represented the industry at meetings of the HCAB.

In 1975, the Department of Health implemented a new payment system, the Standard Hospital Accounting and Rate Evaluation System (SHARE). This system used a uniform cost-reporting system and determined rates by comparing similar hospitals.

The following year, in response to a crisis in availability of malpractice insurance and to soaring premiums, the Health Care Insurance Exchange was formed. It was the first licensed, hospital-owned insurance reciprocal in the United States.

In 1978, with inflation at a fever pitch, the state legislature enacted S-446, a law which set the stage for a statewide prospective payment system. This law created the Hospital Ratesetting Commission with the power to approve rates for all payers of hospital services. It altered the manner in which these rates are approved or adjusted and made major changes in the Health Care Facilities Act of 1971. By extending the state's ratesetting power to all payers, hospital rates were controlled for the privately insured persons and the uninsured as well. The law enabled the state to apply for a federal waiver to set rates for Medicare patients and provided that hospital rates be based on defined "financial elements" which guaranteed that basic costs, such as those for indigent care and bad debts, would be covered. At last there was some real relief promised for hospitals burdened with a disproportionate share of indigent patients.

NJHA devoted considerable effort to help hospitals implement the new reimbursement system, which was based on Diagnosis Related Groups (DRGs), developing management reports, and a comprehensive data base. The Association also worked vigorously to achieve modifications and refinements as needed.

Another issue which began to receive attention from the state and federal governments was licensure of health care personnel. By 1970, over 800 occupations and professions were licensed, and NJHA had writt "Guidelines for Drafting and/or Evaluating Propos Legislation for the Licensing of Health Personnel," c ing for a re-evaluation of the licensing system. T state and federal governments formed study groups 1971 and both referred to the NJHA position paper licensure. The matter of credentialing continued to debated into the next decade.

With the passing years, health care technology b came more complicated and more encompassing, a the issues became even more complex. Professo health care providers, clergy, and ordinary citizens c bated the definition of life and of death, the ethics a economics of access to hi-tech equipment and pr cedures, and the ethics and economics regarding t use of life-support equipment and when to discontin its use. The Karen Quinlan case forced a hard decisi in the New Jersey courts. In 1976, the State Supre Court ruled that patients may be allowed to die if the is "no reasonable possibility of the patient ever emer ing from a comatose condition to a cognitive, sapie state," providing that the patient's prognosis is co firmed by a prognosis or similar type of committe Representatives from state government and pr fessional groups later agreed with the court that t prognosis for the patient's recovery should be the bas for such decisions. Voluntary guidelines were d veloped and subsequently forwarded to New Jersey hospitals to assist them in establishing prognos committees to confirm the attending doctor's opinio that the patient's condition is hopeless. The prognos committee of six or seven physicians was to be co vened at the written request of the patient's family guardian.

In 1977, NJHA moved into its modern facility i Princeton.

THE PRESENT DECADE

In 1982, Louis P. Scibetta, was appointed presiden of the Association. The Association develops position and initiates programs on behalf of hospitals throug a structure of councils and committees, composed c hospital representatives, which report to the NJH Board of Trustees. The councils are: Council on Aux iliaries; Council on Finance; Council on Governmen Relations; Council on Hospital Governance; Council o Management Practices; Council on Planning; an Council on Professional Practice.

Today, hospitals in New Jersey provide quality car in more than 100 communities. Employing som 94,000 workers and spending more than $3 billio annually in the state, hospitals have become one of th state's largest industries.

New Jersey State Nurses' Association

Janet L. Fickeissen, R.N., Lanoka Harbor*

The New Jersey State Nurses' Association has a history of striving to elevate health care standards and services for all people in our state. And today, the Association's activities are as complex and broad as current nursing practices.

The New Jersey State Nurses' Association (NJSNA), the official voice for professional nursing in New Jersey, has a rich history of striving to elevate health care standards and services for all people through high standards of nursing practice. During its 83 years, the Association has matured into a force befitting the largest group of health care providers. The Association was organized on December 4, 1901, at Newark City Hospital where 200 graduate nurses gathered to form an organization which could secure registration and advance the young nursing profession.

At the turn of the century, nursing was not regulated: untrained nurses competed with graduates of training schools. "Residence duty" was the provision of care in the home for 24 hours a day until the patient recovered. The title "nurse" did not connote a professional practitioner; women could be self-proclaimed nurses or have taken correspondence or "short courses" and earn the same $25 weekly fee as the graduate of the finest hospital school of nursing.

Thus, the foremost goal for the the Association was to have a state registration law enacted. In April 1903, the New Jersey bill to license nurses became the second such law in the nation. This simple registration law granted licenses to graduates of two-year hospital training programs. In 1912, the bill was strengthened when Governor Woodrow Wilson signed into effect the law creating the Board of Nurse Examiners, giving nurses an autonomous regulatory board. Raising educational standards, defining the practice of nursing, and licensing nurses continue to be functions of the Board of Nursing.

The early decades of the Association were a time of tremendous growth in both the number of nurses and the scope of nursing in New Jersey. An Association investigation during 1910 focused on county almshouses, revealing sordid conditions: The Essex County Almshouse in Newark housed 240 "inmates" with all types of illnesses; the inmates cared for each other, summoning a physician only to pronounce death. The Nurses' Association formed an Almshouse Committee to rectify such squalor through improved sanitation and isolation of those with communicable diseases. A Committee on Establishing Nurses in Towns in New Jersey then was created to improve public health conditions; this group was the forerunner of community health nurses. In 1907, New Jersey's first visiting nurses were placed in Trenton and Camden as a result of the Committee's work. These early visiting nurses taught venereal prophylaxis and infant welfare and campaigned to eliminate public drinking cups.

During the Depression, the young Association dealt with momentous changes in nursing practice. Few

*Ms. Fickeissen is the History Project Director of the New Jersey State Nurses' Association.

people could afford to hire private duty nurses; the resultant unemployment among nurses was staggering. One registry reported that their nurses averaged only one week of work during 1932. Hospitals employed few if any of the nurses that they trained, relying instead on students to staff the wards under little or no supervision.

The New Jersey State Nurses' Association responded to the crisis by promoting the eight-hour day and encouraging hospitals to hire graduate nurses to supplement the students or untrained attendants who provided meager services to patients. The Association also condemned the proliferation of nursing schools in hospitals; New Jersey alone had 48 hospital schools by 1933, some without a single full-time nursing instructor. Through the Board of Nursing, the Association raised the standards for nursing education by mandating a high school diploma, raising the passing scores on the licensing examination, and requiring at least one full-time nursing instructor in every school.

The nursing glut of the 1930s was replaced by a critical shortage in the 1940s when the nation went to war. To meet the increased demand for nurses, the Association worked to recruit students into nursing schools and classified nurses as essential or available for active duty. Nearly 3,000 New Jersey nurses served in either the Army or Navy Nurse Corps during the war.

To meet the demand for nurses, all 42 of New Jersey's nursing schools participated in the Cadet Nurse program in which students spent their last six months of training in either civilian or military hospitals. To cope with the acute shortages of nurses in civilian hospitals, guidelines were developed by NJSNA for the many auxiliary hospital workers such as aides and volunteers that were needed to supplement the nursing staff. The Association also established a counseling service to assist the large number of inactive nurse to return to nursing for the war effort.

After the war, salaries, benefits, and working con ditions were slow to improve. The Association pushe to reduce the 48-hour work week to 40 hours and t reduce salaries. The Association expended muc energy from the late 1940s through the 1970s on ecc nomic and general welfare issues for nurses.

Changes in the past three decades have been les abrupt than those of the Depression and war, but ar no less revolutionary. With increasing technolog escalating costs, cost containment, and more acutel ill patients, come the need for highly educated an skilled nurses able to give humanistic, cost-effectiv care. Nurses expanded their roles to include th provision of primary care. Nurse practitioner prepared for expanded practice with graduate educa tion and certification in the specialty area. NJSNA cor tributed to the revision of the Nurse Practice Act i 1974 which presently defines nursing as: diagnosin and treating human responses to actual or potentia physical and emotional health problems, through suc services as case finding, health teaching, health coun seling, and provision of care supportive to or restora tive of life and well-being.

Legislation directing Blue Shield reimbursement fo nurses in private practice was passed earlier this yea

Today, the Association's activities are as comple and broad as current nursing practice. Incorporatin nursing resource use into hospital rate structure helping chemically impaired nurses, lobbying for Com parable Worth legislation, detecting and minimizin occupational hazards for nurses, promoting nursin image, and preserving nursing history are only a frac tion of the ongoing activities of the New Jersey Stat Nurses' Association.

New Jersey Medical Historiography, 1964-1984

David L. Cowen, M.A., Litt. D., Rossmoor*

With the growing interest in the history of medicine, the author updates his bibliography on New Jersey medicine. The study indicates the many accomplishments in medicine.

This issue of *The Journal* is an indication of the interest in the history of medicine and allied sciences in New Jersey during the last two decades. There are four factors accounting for this growth: 1) the general interest in history engendered first by the tercentenary of New Jersey and the bicentennial of the United States; 2) the increasing interest in the history of medicine by general historians, social historians, and historians of science; 3) the establishment of the Medical History Society of New Jersey, essentially the accomplishment of Morris H. Saffron, M.D., Ph.D., a man trained as a physician and a historian; and 4) the interest of Arthur Krosnick, M.D., in the history of medicine, and his encouragement of the publication of historical articles in *The Journal*.

The purpose of this paper is to continue and to update the "Bibliographic Notes" that were appended to my *Medicine and Health in New Jersey: A History* (Princeton, 1964), written as part of the state's tercentenary celebration.

GENERAL MEDICAL HISTORY

My 1964 publication, the first full-scale history of medicine of New Jersey—Stephen Wickes's *History of Medicine in New Jersey* (Newark, 1879) stopped at 1800—soon was followed by the more detailed, illustrated, and exemplary, *The Healing Art: A History of the Medical Society of New Jersey* (Trenton, 1966) by Dr. Fred B. Rogers and A. Reasoner Sayre. Although issued in celebration of the bicentennial of the Medical Society of New Jersey, the book is a comprehensive account of the history of medicine in the state: the history of the Society is given within the compass of this general history.

Dr. Rogers presented a brief essay entitled, "The Medical Society of New Jersey Since 1766," to a national audience in *JAMA* (196:645-646, 1966). Morris Fishbein reciprocated with "An Historical Appraisal: The Medical Society of New Jersey" (*J Med Soc NJ* 63:228-236, 1966) which, although rather general, did make reference to the New Jersey experience. Dr. Saffron, in his "New Jersey or Massachusetts," (*JAMA* 245:2031-2032, 1981; *J Med Soc NJ* 79:758-759, 1982) probably has laid to rest any question of the priority of the Medical Society of New Jersey.

Studies of other professional groups have included Samuel Berg's "The Essex County Pathological and Anatomical Society: A Belated Obituary" (*J Med Soc NJ* 66:479-480, 1969) in which the closing of the Society in 1967 is recounted; Dr. Saffron's "Academy of Medicine of New Jersey—A Brief History" (*Bull NJ Acad Sci* 9:5-15, 1964); and Herbert E. Spiegel's "History of the New Jersey Section, AACC" (*Clin Chem* 23, No. 2, Pt. 1:295-296, 1977).

*Dr. Cowen is Professor Emeritus, History, Rutgers University.

A number of other articles of interest to the general history of medicine are to be found in the periodical literature. These include Peter Guthorn's "Calling Dr. Hubbard: Two Hundred Years of New Jersey Medicine" (*J Med Soc NJ* 61:419-421, 1964) which covers the early history of the State Society and describes the medical practices of the Jacobus Hubbards, father and son; Dr. Saffron has described "A Medical Diploma of 1820" (*J Med Soc NJ* 69:684-686, 1972), in which he presents biographical sketches of the signer, Lewis Condict, and the recipient, William Pierson; Saffron also offered "Remarks on New Jersey's Contribution to Medicine" (*J Med Soc NJ* 73:14-15, 1976) in which he briefly recounted the achievements of nine New Jersey physicians; David L. Cowen, Louis D. King, and Nicholas G. Lordi have described the prescribing practices of several Burlington physicians in their "Nineteenth Century Drug Therapy: Computer Analysis of the 1854 Prescription Files of a Burlington Pharmacy" (*J Med Soc NJ* 78:758-761, 1981).

THE REVOLUTION

The New Jersey Historical Society mounted an exhibit on New Jersey medicine in the Revolution. The catalogue of the exhibit, and two historical essays, have been published under the title of the exhibit: *New Jersey Medicine in the Revolutionary Era, 1763-1783* (Newark, 1976). The two essays were: "Medical Background of the American Revolution" by Fred Rogers (pp. 7-8) and Dr. Saffron's major address delivered at the opening of the exhibit on "Medical Men and Events in Revolutionary New Jersey" (pp. 9-16).

Richard Torres-Reye has given a careful, documented account of the medical situation at Morristown in his *Morristown National Park, 1779-1780 Encampment: A Study of Medical Services* (Washington, 1971). Fred Rogers has written on "The Old Barracks at Trenton: Military Hospital of the Revolution" (*J Med Soc NJ* 73:11-13, 1976) in which he pays special attention to William Shippen. Dr. Saffron has written on the "Medical Aspects of the Middlebrook Encampment (*J Med Soc NJ* 76:376-378, 1979).

Fred Rogers's biographical sketch of "Dr. William Bryant (1730-1786) Physician and Antiquary" (*Acad Med NJ Bull* 16, No. 4:18-25, 1970) tells the story of a loyalist physician. Rudolf E. Trice has written a biographical memoir of "Hugh Mercer: Physician Hero of the American Revolution" (*Virginia Med* 108:104-106, 1981), but it makes little reference to Mercer as a physician.

My booklet, *Medicine in Revolutionary New Jersey*, (Trenton, 1975) is a study of the whole Revolutionary scene.

Dr. Saffron's work centering on John Cochran is by far the most significant on the period. His articles include, "John Cochran (1730-1807): Director General of the Hospital of the United States" (*Trans Stud Coll Phys Phila* 43:379-387, 1976); "Dr. John Cochran, the New Jersey Years" (*Acad Med NJ Bull* 16, No. 4:26-34, 1970); "Confrontation in New Jersey: The Hospital Versus the Line" (*J Med Soc NJ* 73:1081-1087, 1976); "The Tilton Affair" (*JAMA* 236:67-72, 1976). Dr. Saffron's studies culminated with *Surgeon to Washington: Dr. John Cochran 1730-1807* (New York, 1977) which contains a biography of Cochran and reprints his letter books.

Finally, reference must be made to Whitfield J. Bell Jr.'s *John Morgan: Continental Doctor* (Philadelphia 1965) which does mention, though scantily, the New Jersey scene.

COUNTY AND LOCAL HISTORY

Dr. Michael A. Nevins has written about Bergen County; his book, *Early Physicians of Northeastern Bergen County* (Spring Valley, 1979), contains many interesting photographs and illustrations, describing 19th and early 20th century medical practice in that part of the county. Nevins also wrote "Bergen County's Poet-Physicians" (*J Med Soc NJ* 77:831-833, 1980) in which he describes the work of Drs. English, Cone, Williams, and Rosner. With Stewart F. Alexander, Nevins authored "Home Care Delivery in Bergen County in the 19th Century" (*J Med Soc NJ* 80:283-287, 1983) based on the records of Dr. Henry C. Neer.

Another work on the local level is that by Norman Reitman, "Medicine and Medical Care in New Brunswick," in R.H. Patt's, *The Tercentennial Lectures, New Brunswick, N.J.* (New Brunswick, 1982).

INDIAN AND FOLK MEDICINE

Clinton Weslager, in *Magic Medicine Among the Indians* (Somerset, 1973) devotes a chapter to "New Jersey 'Sand Hill Indian' Remedies." Susan Hamburger wrote on "Medicine of the Leni Lenape Indians of New Jersey" (*Discovery* [University College, Rutgers University], 25-33, 1975).

A booklet describing the 1979 exhibition at the Newark Museum, *Green Magic: Useful Wild Plants of New Jersey* (Newark, 1979), lists and illustrates 41 plants and gives the medicinal as well as other uses for them.

David S. Cohen has paid some attention to folk medicine; his *The Ramapo Mountain People* (New Brunswick, 1974) contains an appendix on "Herb Cures and Folk Remedies," and *The Folklore and Folklife of New Jersey* (New Brunswick, 1983) has a chapter on medical folklore.

The reprinting of the *Early Recollections and Life of Dr. James Still*, (1970), first published in 1877, recounts the life and career of a self-educated black "doctor" who became known as the "Doctor of the Pines."

SURGERY

The only study of the history of surgery is Henry H. Kessler's, "The Evolution of Orthopedic Surgery and Rehabilitation in New Jersey" (*Acad Med NJ Bull* 13:94-104, 1967).

EDUCATION

The only study related to the history of medical education is my booklet, *Medical Education: The Queens-Rutgers Experience 1792-1836* (New Brunswick, 1966).

PUBLIC HEALTH AND EPIDEMIOLOGY

Two studies dealing with public health in the colonial period are: Larry R. Gerlach's "Smallpox Inoculation in Colonial New Jersey: A Contemporary Account" (*J Rutgers U Lib* 31:21-28, 1967), an annotated description of inoculation methods from the Hen-

Hrickson Family Papers (1753-1787); and William J. Snape and Edward L. Wolfe's "The Studies of Yellow Fever by Noah Webster and John Conrad Otto at Red Bank, New Jersey" (*Bull Gloucester Co Hist Soc* 19, No. 4:25-30, 1984).

Fred Rogers provided a short review in "Medicine and Public Health in New Jersey" (*J Med Soc NJ* 67:541-543, 1970). Stuart Galishoff provided major contributions; his *Safeguarding the Public Health, Newark 1895-1918* is the only book on the history of public health in New Jersey. Galishoff also wrote: "Newark and the Great Influenza Pandemic of 1918" (*Bull Hist Med* 43:246-258, 1969); "The Passaic Valley Trunk Sewer" (*NJ Hist* 88:197-214, 1970); "Cholera in Newark, New Jersey" (*J Hist Med All Sci* 25:438-448, 1970); and "Newark and the Great Polio Epidemic of 1916" (*NJ Hist* 94:101-111, 1976).

The career of Henry L. Coit of Newark is told in Manfred J. Waserman's thorough study: "Henry L. Coit and the Certified Milk Movement in the Development of Modern Pediatrics" (*Bull Hist Med* 46:359-390, 1972).

"Ezra Hunt Mundy—Physician, Writer, Humanitarian" (*J Med Soc NJ* 78:381-385, 1981) by Samuel Alewitz is a study of the leading figure in New Jersey's public health movement.

Samuel Berg, in *Harrison Stanford Martland, M.D.: The Story of a Physician, a Hospital and an Era* (New York, 1978) covers Dr. Martland's work on radium intoxication. The major work has been done by William D. Sharpe: "Harrison S. Martland and the New Jersey Radium Dial Painters" (*Acad Med NJ Bull* 16:55-62, 1970); "Chronic Radium Intoxication: Clinical and Autopsy Findings on Long-Term New Jersey Survivors" (*Envir Res* 8:243-283, 1974); and "The New Jersey Radium Dial Painters: A Classic in Occupational Carcinogenesis" (*Bull Med Hist* 52:560-570, 1978).

Two other papers with relevance to the public health are William D. Sharpe's "Autopsies at Newark City Hospital, 1908-1911" (*J Med Soc NJ* 81:53-62, 1984) and Allen N. Koplin's "Anti-smoking Legislation: The New Jersey Experience" (*J Pub Hlth Pol* 2:247-255, 1981).

MENTAL HEALTH

The only work of substance with a New Jersey orientation on mental health is Frederick M. Herrmann's *Dorothea L. Dix and the Politics of Institutional Reform* (Trenton, 1981).

THE RH FACTOR

One of the significant developments in medical science was the work done on the Rh factor at Newark Beth Israel Hospital by Philip Levine as described in Camp's "Forensic Serology in the United States" (*Amer J Forens Med Pathol* 1:47-55, 1980). Another article on the subject is A.S. Wiener's "Karl Landsteiner, M.D.: History of the Rh-Hr Blood Group System" (*NYS J Med* 69:2915-2935, 1969) and A.G. Erskine and A.S. Wiener, *The Principles and Practice of Blood Grouping* (St. Louis, 1973, pp. 320-322).

MICROBIOLOGY

Claude E. Dolman's concise biography of Theobald Smith and a bibliography of Smith's works can be found in *Dictionary of Scientific Biography* (New York, 1975 Vol. 12, pp. 480-486). Other of Dolman's studies include, "Theobald Smith: Life and Work" (*NYS J Med* 69:2801-2816, 1969); "Texas Cattle Fever: Tribute to Theobald Smith" (*Clio Medica* 4:1-31, 1969); "Theobald Smith and his Presidential Address to the Society of American Bacteriologists" (*ASM News*, 47:231-235, 1981); and "Theobald Smith (1859-1934), Pioneer American Microbiologist" (*Persp Biol Med* 25:417-427, 1982).

The Nobel Prize winning work of Selman Waksman has produced considerable historical attention: *The Conquest of Tuberculosis* (Berkeley, 1964); *Microbiology in New Jersey (Ann Arbor, 1965)*; *"The Road to Streptomycin and Beyond: A Chapter in the History and Application of Antibiotics"* (*Rev Soc Mex Hist Nat* 30:301-306, 1969); and an account of his role in introducing the word "antibiotics" as a noun in the *Journal of the History of Medicine and Allied Sciences* 28:284-286, 1973.

H. Boyd Woodruff, whose autobiographical "A Soil Microbiologist's Odyssey" (*Ann Rev Microbiol*, 1981, 1-28) recounts his experiences working with Waksman and his work in industry with Merck, Sharp and Dohme. Woodruff also has edited *Scientific Contributions of Selman A. Waksman: Selected Articles Published in Honor of his 80th Birthday* (New Brunswick, 1968).

Julius H. Comroe, Jr. has shown how Waksman's interest in soil microbiology developed into an interest in antibiotics and led to the discovery of streptomycin in his "Pay Dirt: The Story of Streptomycin Part I: From Waksman to Waksman" (*Amer Rev Respir Dis* 117:773-781, 1978).

Finally, the most recent work at the Waksman Institute is described by Hubert A. Lechevalier's *The Development of Applied Microbiology at Rutgers* (New Brunswick, 1982).

DENTISTRY

The March 1970 issue of the *Journal of the New Jersey State Dental Society* was devoted to the history of the Society and of dentistry.

Ian C. Bennett's "New Jersey Dental School: History and Progress" (*J NJ Dent Assoc* 10:10-11, 1974) describes the growth of the faculty and students of the school, the introduction of a three calendar year program in 1971, and changes in the curriculum. There also is a "History of the New Jersey State Dental Society" in the *Bulletin of the Union County Dental Society* (48:8-11, 1968).

PHARMACY AND THE PHARMACEUTICAL INDUSTRY

I have written *The New Jersey Pharmaceutical Association, 1870-1970* (Trenton, 1970) covering the history of the Association, vignettes of the history of pharmacy in New Jersey, and a biographical roster of the members of the Association. Louis D. King and I described a dosage form introduced by a nationally known pharmacist from Camden in "George Beringer and the Fluid Glycerates" (*J Am Pharm Assoc* 6:435-438, 1966). I have written on "The Swiss American Pharmaceutical Houses of New Jersey" (Ciba, Hoffmann-LaRoche, and Sandoz) in G. Schramm, *Neue*

Beiträge zur Geschichte der Pharmazie (Zürich, 1978) pp. 37-45. W.H. Helffand, H.B. Woodruff, K.M.H. Coleman, and D.L. Cowen wrote on "Wartime Industrial Development of Penicillin in the United States," *The History of Antibiotics: A Symposium* (Madison, 1980).

HOSPITALS

Nevins, Berg, Sharpe, and Kessler mention hospitals in their works. Only two articles devoted entirely to hospital history have been found: Rosary S. Gilheaney's "Early Newark Hospitals" (*Proc NJ Hist Soc* 83:10-23, 1965) and Thomas J. White's "Frank Hague and the Jersey City Medical Center" (*Acad Med NJ Bull* 16, No. 4:50-53, 1970).

SECTARIAN MEDICINE

H.B. Weiss and H.R. Kemble wrote *The Great American Water-Cure Craze: A History of Hydropathy in the United States* (Trenton, 1967).

R.L. Numbers wrote "Health Reform on the Delaware" (*NJ Hist* 92:5-12, 1974) in which the chief protagonist is Russell Thacher Troll, M.D., who ran the Eastern Hygeian Home at Florence Heights in Burlington County.

Alfred R. Henderson's "Frederick M. Allen, M.D. and the Psychiatric [sic, an error for "Physiatric"] Institute at Morristown, N.J. (1920-1938)" (*Acad Med NJ Bull* 16, No. 4:40-49, 1970), is another selection.

PHYSICIANS AND PATIENTS

The Journal of the Medical Society of New Jersey devoted its September 1983 issue to William Carlos Williams. Other writings about Williams include: Paul Mariani's *William Carlos Williams: A New World Naked* (New York, 1981); Linda W. Wagner's "William Carlos Williams: Poet-Physician of Rutherford" (*JAMA* 204:15-20, 1968); William B. Ober's "William Carlos Williams, M.D. (1883-1963): Physician and Poet" (*NYS J Med* 69:1084-1098, 1969); Nicholas Dewey's "William Carlos Williams: The Writer as a Physician" (*Acad Med NJ Bull* 16:64-73, 1970); and Robert Coles's "William Carlos Williams: A Writing Physician" (*JAMA* 245:41-42, 1981).

Another New Jersey poet, Walt Whitman, has been the subject of study: Charles E. Feinberg, "Medical History: Walt Whitman and His Doctors" (*Arch Intern Med* 114-834, 1964); Harold B. Barnshaw, "Walt Whitman's Physicians in Canada" (*Trans Coll Phys Phila* 31:227-230, 1964); and "Walt Whitman's Medical Problems While in Canada" (*Acad Med NJ Bull* 16, No. 4:35-39, 1970).

A brief account of "The Medical Van Leer Family of Pennsylvania and New Jersey" (*Trans Stud Coll Phys Phila* 38:44-46, 1970) by Dorothy Lansing is a family history.

"Edward Wharton Sprague, M.D., F.A.C.S" by Morris H. Saffron was the leading article in the *Academy of Medicine of New Jersey Bulletin* (16, No. 4:2-11, 1970).

Dr. Morris H. Saffron was the subject of a short sketch describing his bibliophilic interests in *Medico Economics* (57:178-180, 1980) by A.Z. Bain, entitled "How to Profit from Medical History—Collect It."

ORAL HISTORY

The Medical History Society of New Jersey ha undertaken a continuing oral history program unde Stuart Sammis: interviews already have been tape with Morris H. Saffron; James Hillier, the developer o the electron microscope; Richard Leedy, Richard Feig and Paul Smith, osteopathic physicians who practice under the old limited practices arrangements; Josep Gardam, head of the Newark Board of Health for 5 years; Thomas White, chief of medicine at the Jerse City Medical Center for many years; Roy A. Bowers dean emeritus of the Rutgers College of Pharmacy Lena Edwards; and Arthur Bernstein, noted Newar cardiologist. All of the transcriptions will be deposited in the Archives of UMDNJ and at the Academy of Medicine of New Jersey.

HISTORIANS

Milton Asbel has written widely on the history o dentistry and of dental education in the United States Harry Bloch has written vignettes on interesting facets of medical history. Estelle Brodman has written on ora medical history and other topics. Francis Chinard has written on the American physician, Edward Mille Vincent Cirillo has written on early views on bloo fluidity. David L. Cowen continues to write on the history of pharmacy, the materia medica, and related topics. Norman Dain has authored three books on the history of insanity in the United States. G.L. Geison has written on the history of physiology. Gerald Grob has written on the history of mental illness and menta institutions in the United States. William H. Helfand continues his interest in medical and pharmaceutical art and graphics. The late Joseph Kler wrote on Louis Pasteur. Arthur Krosnick has written on the art o Banting. Hubert A. Lechevalier and Morris Solotorovsky have published a history of microbiology Max M. Novich has written on early sports medicine William Ober displays an urbane and catholic interest in the arts, literature, biography, and medical science Gary Puckrein has written on colonial medicine and health. James Reed has written on the history of the birth control movement in the United States. Fred Rogers has written on the practitioners of New England. Morris H. Saffron has continued his interest in medieval medicine. William Sharpe has published on medicine in the Confederacy and on the history of the Pennsylvania Hospital. Judith Walkowitz has written on prostitution in Victorian England. Richard Wedeen has written on the caricatures of gout.

CONCLUSION

The history of medicine is an ongoing and growing discipline in New Jersey. This study indicates not only what has been accomplished, but perhaps, more important, what still remains to be done.

CME CALENDAR

The following is a list of continuing medical education courses for the next two months. Contact the sponsoring organization for further information.

This list is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, The Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the UMDNJ. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

Nov.

20 **Dinner Meeting**
6-9 P.M.—Ramada Inn, Clark
(NJ State Society of Anesthesiologists and AMNJ)

CARDIOLOGY

Oct.

17 **Calcium and Cardiovascular Function**
1:30-5:30 P.M.—Drew University, Madison
(Drew University, CIBA-Geigy Pharmaceutical Division, and AMNJ)

22 **Pharmacological Treatment of**
23 **Cardiovascular Diseases**
8:30 A.M.-5:15 P.M.—Resorts International, Atlantic City
(UMDNJ and AMNJ)

Nov.

15 **Cardiology: Newer Cardiac Drugs**
2-3 P.M.—John E. Runnells Hospital of Union County
(John E. Runnells Hospital and AMNJ)

MEDICINE

Oct.

3 **Venom Therapy**
8-9:30 P.M.—The Manor, West Orange
(NJ Allergy Society and AMNJ)

3 **CDS Prescribing Practices**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)

3 **Endocrine Conferences**
10 3:30-5 P.M.—Rotates between
17 Newark Beth Israel Medical Center,
24 University Hospital, United
31 Hospitals Medical Center, Newark, and VA Medical Center, East Orange
(Endocrinology Section, AMNJ)

3 **Medical Grand Rounds**
10 12 noon-1 P.M.—Rutgers Medical
17 School, Medical Education Bldg.,
24 New Brunswick
31 *(UMDNJ and AMNJ)*

3 **Medicine Morbidity and Mortality Conference**
8-9 A.M.—Rutgers Medical School, Medical Education Bldg., New Brunswick
(UMDNJ and AMNJ)

4 **Immunoregulation: Basic**
11 **Concepts and Applications**
18 4-6 P.M.—Institute for Medical
25 Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

5 **Treatment of Acute Hypertension**
19 **Headache**
9 A.M.—St. Francis Medical Center, Trenton
(St. Francis Medical Center)

9 **Common Problems in Diagnosis and Management of Congenital Infections**
9-10 A.M.—Freehold Area Hospital
(AMNJ)

9 **The Role of the Computer in Dermatology**
8-10 P.M.—Schering Corporation, Kenilworth
(NJ Dermatological Society and AMNJ)

10 **AIDS**
9:30-10:30 A.M.—Bergen Pines County Hospital, Paramus
(AMNJ)

10 **Diet and Cancer—Albert Siegel Memorial**
2-5 P.M.—Saint Barnabas Medical Center, Livingston
(NJ Gastroenterological Society, American Cancer Society, and AMNJ)

10 **Nephrotic Syndrome**
17 **Leukemias in the Adult**
31 **Pulmonary Rehabilitation**
1-2:30 P.M.—VA Medical Center, Bldg. 93, Lyons
(VA Medical Center and AMNJ)

11 **Medical Update: Use of Thyroid Function Tests**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

13 **Hyperthermia for Cancer**
8:30 A.M.-5 P.M.—Medical Society of New Jersey, Lawrenceville
(AMNJ)

17 **Dermatological Conference**
6-9 P.M.—Rutgers Community Health Plan, U.S. Hwy #1 and Rt. 18, New Brunswick
(UMDNJ-Rutgers Medical School)

17 **AIDS**
1:30-2:30 P.M.—Trenton Psychiatric Hospital
(AMNJ)

18 **Rational Approach to Antibiotic Therapy and New Antibiotics**
5-7:30 P.M.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

23 **Calcium Metabolism in a Geriatric Patient**
12 noon-1 P.M.—West Jersey Hospital, Camden
(AMNJ)

24 **Seventh Annual Cancer Symposium**
8-4 P.M.—Executive Motor Lodge, Mount Laurel
(Burlington County Memorial Hospital)

24 **Regional CME Meeting, ACP and NJSIM**
9 A.M.-4 P.M.—Landmark Inn, Woodbridge
(American College of Physicians (New Jersey) and New Jersey Society of Internal Medicine)

27 **Basic and Practical EKG Course**
8:30 A.M.-6 P.M.—Sheraton Heights Hotel, Hasbrouck Heights
(Palisades General Hospital and AMNJ)

30 **AIDS in Children**
7-9 P.M.—Englewood Hospital Learning Center, Englewood
(Englewood Hospital and AMNJ)

30 **Basal Cell Skin Conference**
9 A.M.—Office of Dr. Warshaw, 519 East Broad St., Westfield

Nov.

1 **Immunoregulation: Basic**
8 **Concepts and Applications**
15 4-6 P.M.—Institute for Medical
29 Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

2 **AIDS**
12 noon-1 P.M.—Freehold Area Hospital
(AMNJ)

THE ACADEMY OF MEDICINE OF NEW JERSEY
presents
a symposium on

HYPERTHERMIA FOR CANCER

Saturday, October 13, 1984
8:30 a.m.-3:00 p.m.
at
MSNJ Headquarters, Lawrenceville, N.J.

For further information contact:

EXECUTIVE OFFICES
The Academy of Medicine of New Jersey
Two Princess Road
Lawrenceville, NJ 08648
(609) 896-1717

The Academy of Medicine of New Jersey, Physicians for Social Responsibility, Northern New Jersey Chapter, Department of Preventive Medicine and Community Health, UMDNJ-New Jersey Medical School present
a symposium on

POTENTIAL HUMAN AND ECOLOGICAL DISASTERS

Saturday, October 20, 1984
9:00 p.m.-3:00 p.m.
at
Town & Campus Restaurant
West Orange, New Jersey

For further information contact:

EXECUTIVE OFFICES
The Academy of Medicine of New Jersey
Two Princess Road
Lawrenceville, NJ 08648
(609) 896-1717

The Academy of Medicine of New Jersey
Association for Hospital Medical Education of New Jersey
The Medical Society of New Jersey
presents
a workshop on

CME ESSENTIALS

Wednesday, September 19, 1984
8:30 a.m.-4:00 p.m.
at
MSNJ HEADQUARTERS, Lawrenceville

Those CME managers and planners in attendance will: Gain exposure to a broad range of needs assessment procedures from faculty and fellow participants; Choose those needs assessment concepts and techniques which will best apply to their particular environment; Observe one or more accreditation site survey scenarios and determine the collegial and consultative nature of the site survey process and define what is expected in the accreditation and site survey process.

PROGRAM CO-CHAIRMAN:
Alfred A. Alessi, M.D.
Director of Medical Education
Academy of Medicine of New Jersey
Brewster Miller, M.D.
Director of Medical Education
Somerset Medical Center

for further information contact:

EXECUTIVE OFFICES
The Academy of Medicine of New Jersey
Two Princess Road, Lawrenceville, NJ 08648
(609) 896-1717

LIKOFF CARDIOVASCULAR INSTITUTE

of Hahnemann Medical College & Hospital
230 N. Broad Street, Philadelphia, Pennsylvania 19102 (215) 448-8063

CARDIOLOGY UPDATE. . .

IS DESIGNED FOR THE PHYSICIAN AND PROVIDES AN INTENSIVE SURVEY OF THE CURRENT STATUS OF CLINICAL CARDIOLOGY. . .

OCTOBER 3, 1984

ACUTE MYOCARDIAL INFARCTION

MODERATOR: WILLIAM FRANKL, M.D.

3:00 CASE PRESENTATION — *Edward Catherwood, M.D.*
3:30 RELATIVE VALUE OF TREADMILL EXERCISE TESTING — *Stuart Snyder, M.D.*
4:00 THALLIUM IMAGING AND RADIONUCLIDE ANGIOGRAPHY EARLY AFTER MYOCARDIAL INFARCTION — *Abdulmassih S. Iskandrian, M.D.*
4:30 CORONARY ARTERIOGRAPHY FOR PATIENTS WITH ACUTE MYOCARDIAL INFARCTION: SHOULD IT BE DONE IN ALL PATIENTS? — *Charles E. Bemis, M.D.*
5:00 THROMBOLYSIS IN ACUTE MYOCARDIAL INFARCTION: INDICATIONS, NEW AGENTS, AND RESULTS — *Demetrios Kimbiris, M.D.*

LECTURE HALL "A"—2nd floor New College Building, Hahnemann University
15th and Vine Streets, Philadelphia, PA

• NO REGISTRATION FEE • NO ADVANCE REGISTRATION REQUIRED •
• CME CATEGORY I CREDITS CERTIFIED •
WINE & CHEESE SERVED FOLLOWING CONFERENCE

2 **ND-YAC Laser in G.I.**
16 **The Physician as a Patient**
30 **Sanity in Today's Beta-Blocker Market**
9 A.M.—Crean Hall, St. Francis Medical Center, Trenton
(St. Francis Medical Center)

6 **Antibiotic Update**
9-10 A.M.—Freehold Area Hospital
(AMNJ)

7 **AIDS**
1-2:30 P.M.—Christ Hospital, Jersey City
(AMNJ)

7 **Medical Grand Rounds**
14 12 noon-1 P.M.—Rutgers Medical
21 School, Medical Education Bldg.,
28 New Brunswick
(UMDNJ and AMNJ)

7 **Medicine Morbidity and Mortality Conference**
8-9 A.M.—Rutgers Medical School, Medical Education Bldg., New Brunswick
(UMDNJ and AMNJ)

7 **Common Dermatoses**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)

7 **Endocrine Conferences**
14 3:30-5 P.M.—Rotates between
21 Newark Beth Israel Medical Center,
28 University Hospital, United Hospitals Medical Center, Newark, and VA Medical Center, East Orange
(Endocrinology Section, AMNJ)

13 **Topic To Be Announced**
8-10 P.M.—Schering Corp., Kenilworth
(NJ Dermatological Society and AMNJ)

14 **Early Diagnosis and Treatment of Commonly Seen Office Problems**
8:30 A.M.-5 P.M.—Medical Society of NJ, Lawrenceville
(NJ Academy of Family Physicians and AMNJ)

14 **Dermatologic Manifestations of Life-Threatening Illness**
1-2:30 P.M.—Bldg. 93, VA Medical Center, Lyons
(VA Medical Center and AMNJ)

15 **Diagnosis and Management of Anaerobic Infection**
5-7:30 P.M.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

15 **Case Presentations**
8-10 P.M.—The Mountainside Hospital, Montclair

***The Journal* of the**
Medical Society of New Jersey
presents

300 YEARS OF MEDICINE IN NEW JERSEY

September 1984

We are celebrating the history of medicine in New Jersey. This special issue illuminates the beginnings of our health care system and the growth of medical care: essays highlight those talented individuals who devoted themselves to this system, and commentaries present the development of specialized care in associated fields of medicine. Plus a special photography section highlighting three statewide exhibits.

Copies of this issue are available by sending $5.00 (check or money order) to MSNJ, Two Princess Road, Lawrenceville, NJ 08648. All MSNJ members will receive one copy of this issue.

Name _____

Address _____

_____

Enclose a $5.00 check or money order for each copy.

ARE YOU A SAINT MICHAEL'S ALUMNUS?

Saint Michael's Medical Center, Newark, NJ, a 117 year old teaching hospital, is forming a medical alumni association. We are seeking some 5,000 physicians who served as residents and interns. Over the years many of our former house staff members have relocated making consistant communication difficult.

Our alumni association will be oriented towards four goals: professional, medical, social and educational. Plans are already being made for a medical reunion dinner and symposium in the fall.

If you are a former member of Saint Michael's house staff or know another staffer's whereabouts, please call (201) 877-5494 or write to:

SAINT MICHAEL'S MEDICAL CENTER
268 Dr. Martin Luther King, Jr. Blvd.
Newark, NJ 07102
attn: Office of Public Affairs

ACUPUNCTURE IN CLINICAL PRACTICE

N.Y. State Boards of Medicine & Dentistry 25-hour accredited seminar and workshop on the latest theories & techniques of manual and electro-acupuncture, applicable toward the 200-hour requirement for certification, will be given for licensed clinicians (with or without prior training) during the weekend of Sept. 9-11, 1984 and again the weekend of Oct. 26-28, 1984 at the Barbizon Plaza Hotel, New York City. Co-sponsored by the International College of Acupuncture & Electro-Therapeutics, its office journal, Acupuncture & Electro-Therap. Res., Int.J. (published by Pergamon Press and indexed in 15 major indexing periodicals; INDEX MEDICUS, etc.), the Heart Disease Research Foundation and the Neuroscience Dept. of Long Island College Hospital, Pharmacology Dept. of The Chicago Medical School. Also eligible for AMA/CME credit. For information, contact Y. Omura, M.D., ScD., 800 Riverside Drive (8-1), NYC 10032. Tel: (212) 781-6262 or (212) WA8-0658, or Saul Heller, M.D., Tel: (212) 838-7514.

TAX SHELTERS

Just one of the personal financial services available to you from the ***physician's bank.***

- tax planning
- lines of credit
- equipment financing
- retirement planning

- money management
- cash flow • investments
- estate planning

Call or Write
Joseph J. Verbaro, Jr.
Senior Vice President
(201) 228-9770

FINTRUST
FINANCIAL AND TRUST SERVICES
DIVISION OF SECURITY NATIONAL BANK & TRUST COMPANY OF NEW JERSEY
101 Eisenhower Parkway
Roseland, New Jersey 07068 Member F.D.I.C.

NEW YORK FERTILITY RESEARCH FOUNDATION, INC.

For the Investigation of
Problems of Human Infertility

The Foundation provides a complete diagnostic and consultation service for infertile couples. Investigations are conducted by well-known specialists in conjunction with consultants in the various fields of medicine related to infertility.

The Foundation is supported by an in-house modern laboratory equipped to do most tests required for diagnosis and treatment. Literature on request.

1430 Second Avenue, Suite 103
New York, N.Y. 10021
Phone: (212) 744-5500

(NJ Gastroenterological Society and AMNJ)

20 **New Treatment Modes and Implications for the Future in Diabetes**
12 noon—St. Mary's Hospital, Orange
(St. Mary's Hospital and AMNJ)

21 **Dermatological Conferences**
6-9 P.M.—Rutgers Community Health Plan, U.S. Hwy. 1 & Rt. 18, New Brunswick
(UMDNJ and AMNJ)

28 **Dermatologic Manifestations of Life-Threatening Illness**
1-2:30 P.M.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

28 **Controversies in Geriatrics**
1-5 P.M.—Medical Society of NJ, Lawrenceville
(AMNJ)

29 **Laser Treatment of Massive GI Hemorrhage**
11 A.M.-12 noon—St. Joseph's Hospital and Medical Center, Paterson
(AMNJ)

NEUROLOGY/PSYCHIATRY

Oct.

1 **Cocaine Addiction in a Hysterical Woman**
8:15-10:30 P.M.—Marquette Road, Upper Montclair
(Essex Psychiatric Seminar and AMNJ)

3 **Use of Botulin Toxin To Treat Essential Blepharospasm**
6-9 P.M.—The Manor, West Orange
(AMNJ)

4 **Research Update: Aging, The Elderly, and E.C.T.**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

5 **Lecture Series**
12 1:30-5:30 P.M.—Trenton
19 Psychiatric Hospital
26 *(NJ Division of Mental Health and Hospitals and AMNJ)*

11 **Gender, Identity, Cognitive Development, and Emotional Conflict**
8 P.M.—Saint Barnabas Medical Center, Livingston
(NJ Psychoanalytic Society and AMNJ)

15 **Lecture Series**
8:30-10:30 P.M.—301 Broad Ave., Englewood
(NJ Psychoanalytic Society and AMNJ)

16 **Current Management of Intracerebral Hemorrhage**
12 noon—St. Mary's Hospital, Orange
(AMNJ)

17 **Personality Variables in Substance Abuse**
1-3 P.M.—Fair Oaks Hospital, Summit
(Fair Oaks Hospital and AMNJ)

18 **Coordination of Psychiatric Treatment in the Hospital and Community**
3-4 P.M.—Ancora Psychiatric Hospital, Hammonton
(Ancora Psychiatric Hospital and AMNJ)

19 **The State of Psychiatry for 1984**
8:30-10:30 P.M.—Coachman Inn, Cranford
(NJ Psychiatric Association and AMNJ)

23 **Alzheimer's Disease**
24 9:15 A.M.-4:45 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

24 **Affective Disorders: New Advances in Diagnosis and Treatment**
1-3 P.M.—Fair Oaks Hospital, Summit
(Fair Oaks Hospital and AMNJ)

Nov.

1 **Psychotherapy Outcome Research**
8 **The Wish To Be Held**
15 **Smoking, Personality, and Health**
29 **Humor In Psychotherapy**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

2 **Lecture Series**
9 1:30-5:30 P.M.—Trenton
16 Psychiatric Hospital
23 *(NJ Division of Mental Health and*
30 *Hospitals and AMNJ)*

3 **Clinical Issues in Adoption**
8:30 A.M.-5 P.M.—Fair Oaks Hospital, Summit
(Fair Oaks Hospital and AMNJ)

5 **Psychosomatic Disorder Followed by a Tic**
8:15-10:30 P.M.—192 Chittenden Road, Clifton
(Essex Psychiatric Seminar and AMNJ)

7 **Therapeutic Touch—Research and Clinical Findings**
1-2:30 P.M.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

7 **Louis Loeser Memorial Lecture**
8-10 P.M.—South Mountain School, South Orange
(NJ Psychiatric Association, NJ Medical School and AMNJ)

8 **Certain Aspects of Forensic Psychiatry Applicable to the Chronic Care Psychiatric Hospital**
1-3 P.M.—Essex County Hospital Center, Cedar Grove
(Essex County Hospital and AMNJ)

14 **Industrial/Occupational Medicine and Psychiatry**
9:15 A.M.-4:30 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

15 **Topic To Be Announced**
8:30 P.M.—Hackensack Medical Center
(NJ Psychoanalytic Society and AMNJ)

15 **Psychopharmacology I**
29 **Psychopharmacology II**
3-4 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

19 **Lecture Series**
8:30-10:30 P.M.—301 Broad Ave., Englewood
(NJ Psychoanalytic Society and AMNJ)

OBSTETRICS/GYNECOLOGY

Oct.

25 **Semi-Annual Meeting**
9 A.M.-5 P.M.—Rutgers Medical School, Piscataway
(NJ Obstetrical and Gynecological Society and AMNJ)

PATHOLOGY

Oct.

25 **DES—An Update**
11 A.M.-12 noon—St. Joseph's Hospital and Medical Center, Paterson
(St. Joseph's Hospital and AMNJ)

Nov.

17 **Surgical Pathology of the Breast: Diagnosis and Therapeutic Implications**
9 A.M.-1 P.M.—Rutgers Medical School, Piscataway
(NJ Society of Pathologists and AMNJ)

PEDIATRICS

Oct.

10 **Pediatric Gastroenterology Update for the Practitioner**
9 A.M.-3 P.M.—Newark Beth Israel Medical Center
(Newark Beth Israel Medical Center and AMNJ)

17 **Childhood Oncology of the Bone, Blood, and Brain**
1-4 P.M.—Rutgers Medical School, Medical Education Bldg., New Brunswick
(UMDNJ and AMNJ)

20 **First Annual Tri-State Gifted Conference**
9 A.M.-3 P.M.—Camden County College, Blackwood
(Educational Information and Resource Center)

30 **AIDS in Children**
7-9 P.M.—Englewood Hospital Learning Center, Englewood
(Englewood Hospital and AMNJ)

Nov.

6 **Newer Aspects of Pneumonia in Infants and Children**
8:30-9:30 A.M.—Newark Beth Israel Medical Center
(Newark Beth Israel Medical Center and AMNJ)

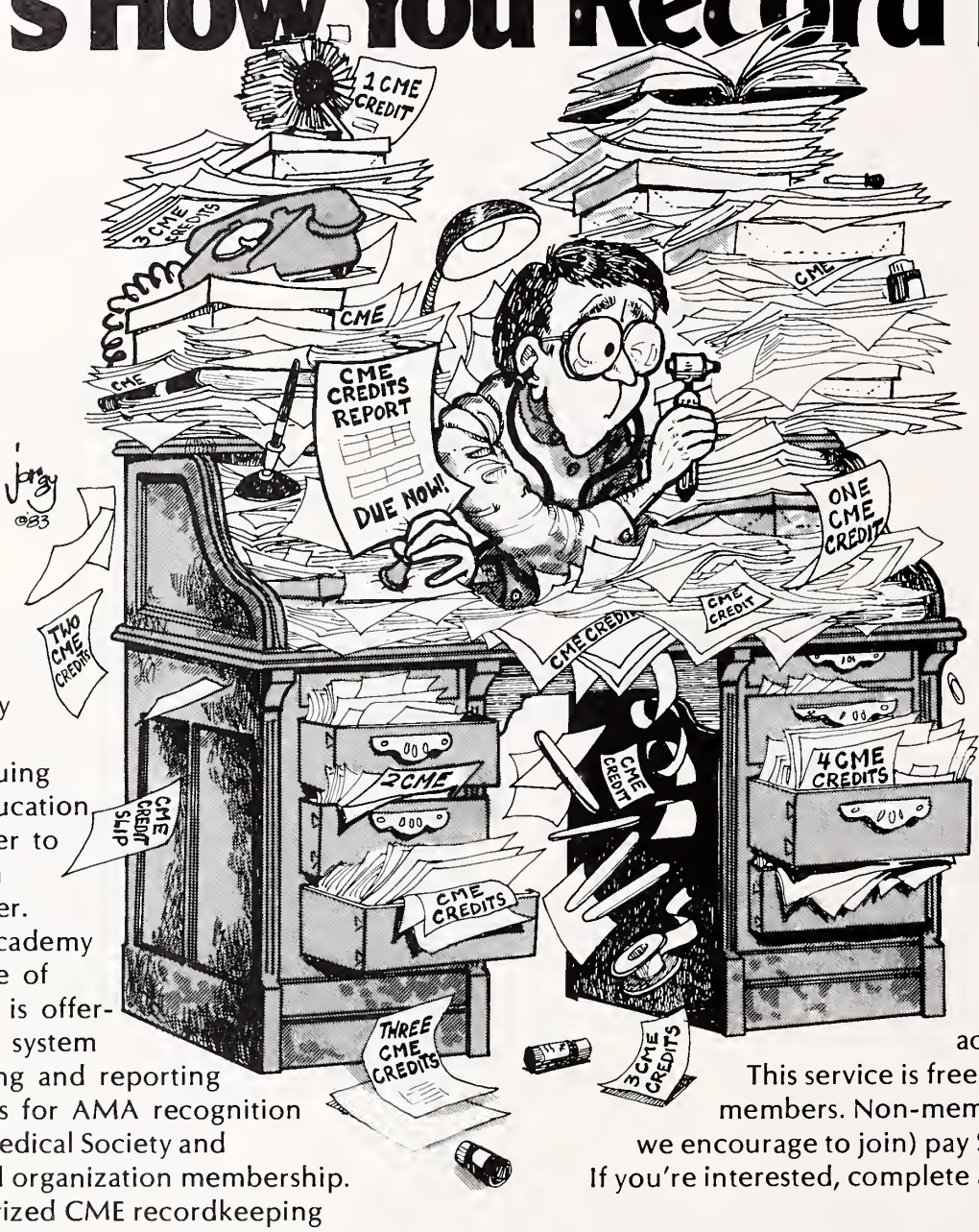
7 **Current Diagnosis and Management of Pediatric Rheumatologic Diseases**
8:30 A.M.-2 P.M.—Rutgers Medical School, Piscataway
(Arthritis Foundation, NJ Chapter, NJ Rheumatism Association, and AMNJ)

RADIOLOGY

Oct.

11 **New Aspects of Ultrasonography**
18 Saint Barnabas Medical Center, Livingston
(NJ Institute of Ultrasound in

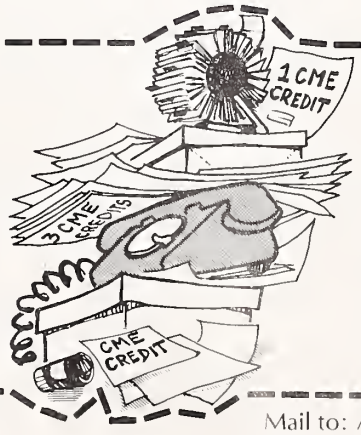
It's Not What You Know, It's How You Record It.



Most busy physicians find continuing medical education credits easier to collect than to remember.

So the Academy of Medicine of New Jersey is offering an easy system for recording and reporting CME credits for AMA recognition as well as Medical Society and professional organization membership. A computerized CME recordkeeping system is available to every New Jersey physician. All you do is send us a reporting card (which your office staff can complete). We'll keep your records and keep you informed semi-annually of your accumulation. This service is free to Academy members. Non-members (whom we encourage to join) pay $30 per year. If you're interested, complete and mail this coupon.

Note: The Medical Society of New Jersey accepts these CME Reports as documentation to meet CME membership requirements.



Please register me for AMNJ's computerized CME record-keeping service.

Name _____

Address _____

City _____ State _____ Zip _____

Telephone Number _____

Your New Jersey Medical License No. (five numerical digits only)_ _ _ _ _

Academy member: Yes ☐

No ☐ Please enclose check

Interested in Academy membership: Yes ☐ No ☐

Mail to: Academy of Medicine of New Jersey, 2 Princess Road, Lawrenceville, NJ 08648

Medicine, Radiological Society of NJ, and AMNJ)

25 **Visiting Professorship Program**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(Dept. of Radiology, Saint Barnabas Medical Center, and AMNJ)

Nov.

8 **Current Status of Carotid Imaging**
7:30 P.M.—Saint Barnabas Medical Center, Livingston
(NJ Institute of Ultrasound in Medicine, Radiological Society of NJ, and AMNJ)

21 **Radiation Therapy Oncology Group**
6:30-9:30 P.M.—The Manor, West Orange
(Radiotherapy Section, AMNJ)

SURGICAL SPECIALTIES

Oct.

23 **Ophthalmology Update 1984-1985**
8-10 P.M.—Englewood Club, Englewood
(Englewood Surgical Society and AMNJ)

Nov.

27 **Breast Reconstruction After Mastectomy**
8-10 P.M.—Englewood Club, Englewood
(Englewood Surgical Society and AMNJ)

MISCELLANEOUS

Oct.

4 **Medical Hypnosis Course**
11 4-8 P.M.—Carrier Foundation, Belle
18 Meade
(Carrier Foundation and AMNJ)

17 **Most Useful Visual Aids for Geriatric Patients**
7:30 P.M.—Saint Barnabas Medical Center, Livingston
(Ophthalmology Section, AMNJ)

18 **Computers in Medicine**
11 A.M.-12 noon—St. Joseph's Hospital and Medical Center, Paterson
(AMNJ)

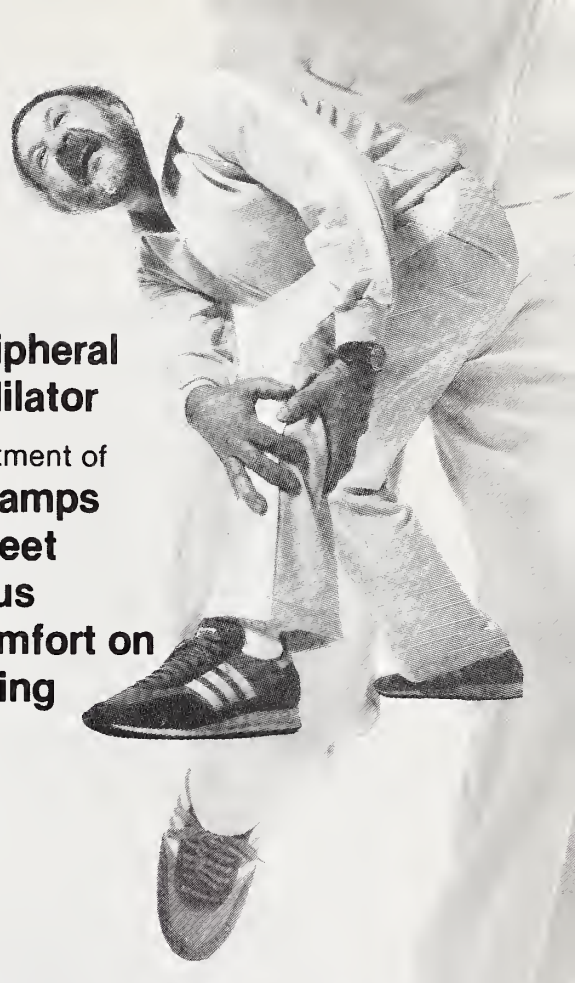
18 **Nurse as Expert Witness in Court**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

20 **Potential Ecological and Medical Disasters**
8:30 A.M.-3:30 P.M.—Location to be announced
(NJ Chapter of Physicians for Social Responsibility and AMNJ)

Nov.

1 **Medical Hypnosis Course**
8 4-8 P.M.—Carrier Foundation, Belle
15 Meade
29 *(Carrier Foundation and AMNJ)*

14 **Withholding or Withdrawal of Life Support—Legal and Ethical/Moral Aspects**
8:30 A.M.-3:30 P.M.—Hilton Inn, Tinton Falls
(NJ Society of Critical Care Medicine and AMNJ)



A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy



For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release
LIPO-NICIN®/300 mg.

Each time-release capsule contains:
Nicotinic Acid .....300 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release
LIPO-NICIN®/250 mg.

Each yellow tablet contains:
Nicotinic Acid .....250 mg.
Niacinamide .....75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide .....75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

Kirwan Financial Group, Inc.

Financial Planners
for the
Medical Profession

Investments, Pensions, Insurance, Etc.

- Honest
- Sophisticated
- Profusely Referenced

609-778-4388

MEDICAL PRACTICE
SALES AND APPRAISALS

We specialize in the valuation and selling of medical practices. If interested in buying or selling a medical practice, contact our Brokerage Division at:

Health Care Personnel Consulting, Inc.
403 GSB Building
1 Belmont Avenue
Bala Cynwyd, PA 19004
215-667-8630

The *Journal* of the Medical Society of New Jersey
announces the reprinting of the

WILLIAM CARLOS WILLIAMS COMMEMORATIVE ISSUE

September, 1983

Honoring the 100th anniversary of the birth of New Jersey's prize-winning poet and physician. Included in this handsomely illustrated, full-color issue will be original articles by persons close to William Carlos Williams, artwork from his social and intellectual circle, and samples of his finest writings.

Copies of this special issue are available by sending $5.00 for each (check or money order) to MSNJ, Two Princess Road, Lawrenceville, NJ 08648.

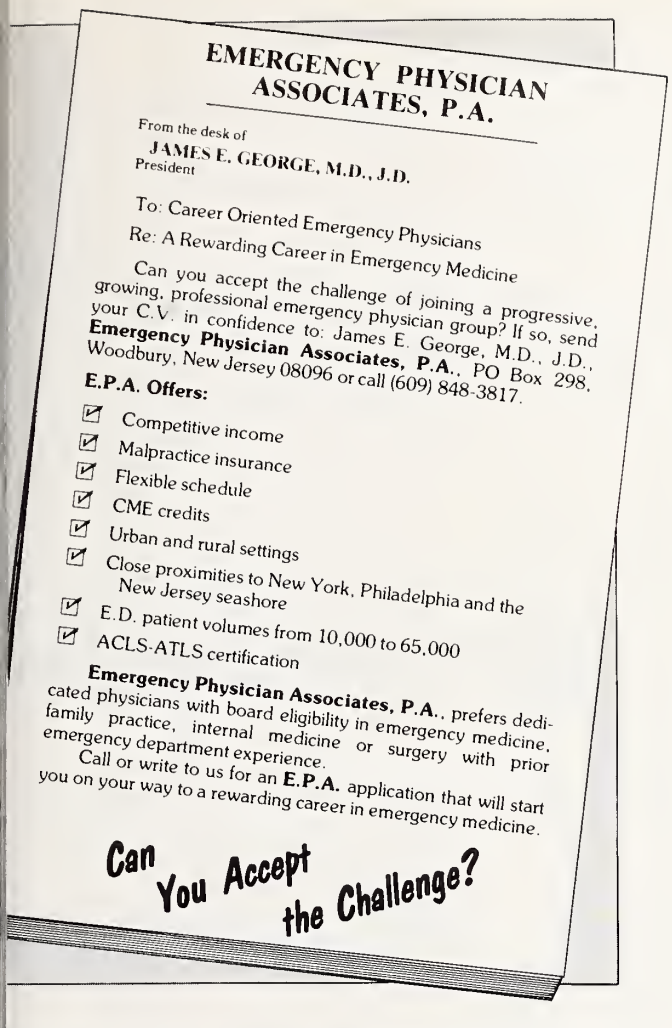
Please send a copy of the **William Carlos Williams Commemorative Issue** to:

_____

_____

_____

Enclose a $5.00 check or money order for each copy.


EMERGENCY PHYSICIAN ASSOCIATES, P.A.

From the desk of
JAMES E. GEORGE, M.D., J.D.
President

To: Career Oriented Emergency Physicians

Re: A Rewarding Career in Emergency Medicine

Can you accept the challenge of joining a progressive, growing, professional emergency physician group? If so, send your C.V. in confidence to: James E. George, M.D., J.D., **Emergency Physician Associates, P.A.**, PO Box 298, Woodbury, New Jersey 08096 or call (609) 848-3817.

E.P.A. Offers:

- ☑ Competitive income
- ☑ Malpractice insurance
- ☑ Flexible schedule
- ☑ CME credits
- ☑ Urban and rural settings
- ☑ Close proximities to New York, Philadelphia and the New Jersey seashore
- ☑ E.D. patient volumes from 10,000 to 65,000
- ☑ ACLS-ATLS certification

Emergency Physician Associates, P.A., prefers dedicated physicians with board eligibility in emergency medicine, family practice, internal medicine or surgery with prior emergency department experience.

Call or write to us for an **E.P.A.** application that will start you on your way to a rewarding career in emergency medicine.

Can You Accept the Challenge?

It's Your Affair, So Don't Lift A Finger

Since we want your special day to be carefree just lift the phone and call

Parties Unlimited

Perfect Catering For A Perfect Affair

Trenton, New Jersey
609-890-0778

DOCTORS:

Are your billing, filing and business systems in your office running as smoothly and efficiently as your medical practice?

If not, Mary Ann Hamburger, Associates is your answer. Sixteen years ago Mary Ann Hamburger of Maplewood, New Jersey took a job for a doctor managing this office. Today, as a medical management consultant, Mary Ann knows where the problem areas are and she can make sure that everything runs smoothly for the physician and his or her staff. Part of her job is to make certain that the current billing system is running efficiently, to update the filing system, work with third party billing, help clear up any booking problems as far as appointments are concerned and work with any other problems relating to the business side of the medical practice.

Mary Ann's skills will benefit any doctor in an existing practice and all new doctors who are setting up their practices in the near future. Her services can also include the hiring aspect of the doctor's offices if desired.

FOR FURTHER INFORMATION ON MEDICAL MANAGEMENT, CONTACT MARY ANN HAMBURGER, ASSOCIATES AT 201-763-7394.

MEDICAL COMPUTERS

DEC - IBM - TELEVIDEO ALTOS - NCR

THINKING OF COMPUTERIZING YOUR PRACTICE?

FBL MEDICAL COMPUTER SPECIALISTS offers a wide variety of hardware/software configurations for every medical office, hospital and clinic application.

- AUTOMATIC INSURANCE FORM PREPARATION
- ACCOUNTS RECEIVABLE CONTROL
- AUTOMATIC PATIENT RECALL
- PRACTICE MANAGEMENT REPORTS
- CLINICAL RECORDS
- ACCOUNTS PAYABLE
- APPOINTMENT SCHEDULING
- ELECTRONIC CLAIMS SUBMISSION
- WORD PROCESSING
- MEDICARE/MEDICAID BILLING
- GENERAL LEDGER
- INVENTORY

UNIX SOFTWARE AVAILABLE FOR ALTOS AND NCR
MUMPS SOFTWARE AVAILABLE FOR DEC

SPECIALISTS IN MULTI-USER, MULTI-TASKING DATA-BASE MANAGEMENT SYSTEMS.

FBL

PROVIDING YOU WITH OVER 15 YEARS OF MEDICAL COMPUTER EXPERIENCE

CONSULTING SERVICE AVAILABLE

3 ROUTE 46W, FAIRFIELD, N.J. 07006 201-882-9210

NEUROLOGIST wanted for diagnosis, treatment and patient care in all areas of neurology; Requires M.D. degree and three years training as a resident in neurology; 40 hours per week; $66,500.00 per year. Position located in Southern New Jersey. Mail resume to CN053, A.E.C. #74, Trenton, N.J. 08625. Resumes must be received within two weeks of publication date of this advertisement.

PRIMARY CARE PHYSICIAN—Family Practice or Internal Medicine BE/BC—Solo and partnership opportunities, immediate and July 1985, in central New Jersey; convenient to Philadelphia and New York; excellent local housing, schools, universities, cultural activities; hospital affiliation in 350 bed full service facility; financial assistance available; preference given to graduates of major medical schools and programs; reply box

NJ Physician Recruitment Association
P.O. Box 35
Pennington, NJ 08534

Need A Temporary Physician?

CompHealth treats your practice as if it were our own during: vacations, CMEs, recruiting, clinic start-up or other absences.

Want Free Time While You Practice Medicine?

Join CompHealth's Locum Tenens Physician Group.

★

For further information about temporary coverage or locum tenens practice opportunities, call:

CompHealth

A Physician Group

WILSON ROSS, Regional Administrator
244 East Hanover St.
Trenton, NJ 08608
Telephone: 609-392-1111



AIR FORCE

A great way of life.

A SPECIAL PRACTICE FOR SPECIALISTS

If you're a surgeon or OB/GYN or other medical specialist, the Air Force may have a special practice for you.

What makes it special? You'll enjoy an excellent pay and benefits package. Your regular working hours will allow you to spend more time with your family. You'll receive 30 days of vacation with pay each year. And you will work with modern equipment and some of the most highly trained professionals in the world, serving your country and your patients. Now that's special! Find out just how special your practice can be.

Contact:
Maj. Sandra Klassy
609-723-0455

CLASSIFIED ADVERTISEMENTS

OBSTETRICS-GYNECOLOGY—Board eligible, NJ licensed, subspecialty fellowship experience in Micro-surgery, Hysteroscopy, Infertility, Artificial insemination, Gyn-endocrinology. Seeks practice opportunity. Available now. Write Box No. 96, JMSNJ.

ORTHOPAEDIC SURGEON—American graduate, trained at Downstate Medical Center, NY. Seeks position, solo, group or hospital based. Call 212-819-8706 (business hours).

PHYSICIAN—Lifetime NJ resident seeks position in a pediatric group after completion of postgraduate training. Available July 1985. Please contact Charles Geneslaw, 8372 Loveridge Court. Richmond, VA 23229.

PHYSICIAN—MD for industrial and occupational health care facility in the South Jersey resort area. Opening November or December. Duties to include emergency, follow-up/and return to work treatment, as well as pre-placement and annual physical exams. Send CV to Box No. 95, JMSNJ.

NEEDED PHYSICIANS—For successful well known walk-in medical office center. Central NJ. Full and part time, skilled personable American-trained MDs. Send CV to E.V. McGinley, MD, 1005 N. Washington Avenue, Green Brook, NJ 08812. 201-968-8900.

EQUIPMENT FOR SALE—Various office items including physical therapy equipment. Please phone for full listing or information. Livingston. 201-994-3200.

FOR SALE—45-year old Family Practice in East Orange, NJ. Must sell due to death of physician. Contact: A. D. Rosen, 14333 Addison Street, #115, Sherman Oaks, CA 91423. 818-789-2715.

FOR SALE—South Orange, 3 story home, professional zone near all transportation within 10 minutes of St. Barnabas, St. Marys Hospital and Hospital Center at Orange. Please address inquires to Box No. 92, JMSNJ.

OFFICE SPACE TO SUBLET—Beautifully furnished office in professional building in prestigious Haddonfield, South Jersey. Ideal for surgeon or subspecialist. 609-354-1511.

OFFICE SPACE TO SUBLET—Livingston. 349 E. Northfield Road, near St. Barnabas. Fully furnished, all utilities included. Close to public transportation. Available immediately. 201-992-4442.

OFFICE SPACE TO SHARE—Morristown, central location. Near hospital, fully equipped, newly decorated. All utilities included. Ample parking available. Near public transportation. Available immediately. (201) 267-2555.

OFFICE SPACE TO SHARE—North Brunswick/Somerset. Fully equipped pediatricians' office located on Highway 27 in North Brunswick/Somerset area, in new professional building. Call 201-828-4850 for information.

OFFICE SPACE TO SHARE—Westfield, central location. Near hospital, fully equipped, attractively decorated. All utilities included. Ample parking available. Near public transportation. Available immediately. (201) 267-2555.

OFFICE SPACE—Atlantic City. For rent, medical office fully equipped and furnished. 1,300 square feet. Call 609-822-0270.

OFFICE FOR SHARE or RENT—New Brunswick, Highland Park area. Furnished, 700 square feet. Ample parking. Close to the hospital. $500/month plus utilities, for rent. For share, $300/month including utilities. Call 201-572-5050 or 572-7553.

OFFICE SPACE—South Orange. Complete professional office for rent. 1,500 square feet, parking. Telephone 201-751-3300.

OFFICE SPACE—For Rent. Professional office for rent in West New York. Corner location with parking space on Doctor's row. Close to hospital and public transportation. Call 201-278-1000 or 201-947-4333.

FOR RENT—Professional office space for rent. Millburn prestigious building, 775 square feet. On-site parking, on bus route. Call 201-731-1900.

RATE INFORMATION FOR MEMBERS: $5.00 per insertion up to 25 words; 10 cents each additional word. Payable in advance. **WORD COUNT:** Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one word, and "Write Box No. 000, c/o JMSNJ" as six words. **COPY DEADLINE:** Fifth of preceding month.

PRACTICE FOR SALE

Pediatric Practice—Northeast New Jersey. Established, growing practice. Attractive lease, good staff, fully equipped, pleasant community.

Address inquiries to:

The Health Care Group
400 GSB Building
Bala Cynwyd, PA 19004
215-667-8630

It's A Major Medical Explosion

The Lakewood, Toms River and Point Pleasant hospitals are all going ahead with major expansion programs... Bricktown opens new facility.

Cross River Professional Center

400 to 2,300 Square Feet

¼ Mile South of Kimball Medical Center

- $12 per square foot
- Graduated rent schedules
- Ownership options available
- Fully landscaped
- Centrally located and 10 minutes to all four major hospitals
- Private entrances and all services available
- Equipment leases available

BARRYMOR ENTERPRISES Brokers Protected

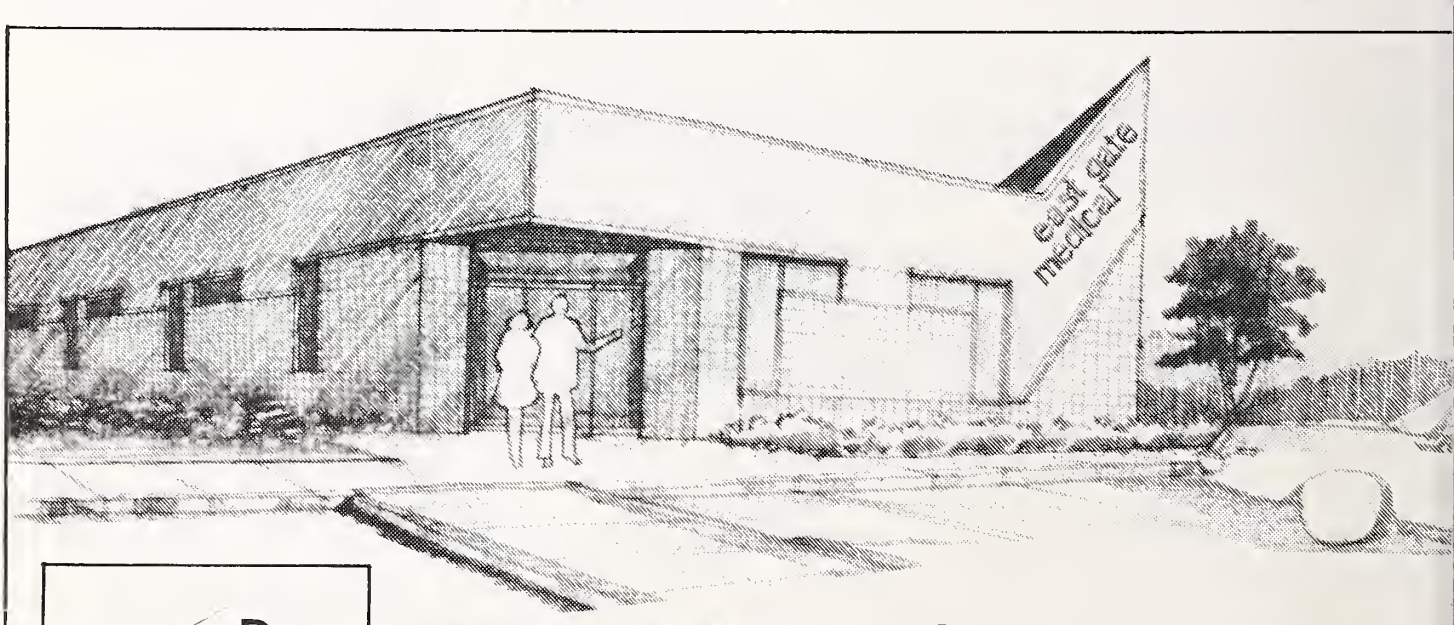
1200 River Avenue (Route 9), Lakewood, NJ 08701 • (201) 367-2226

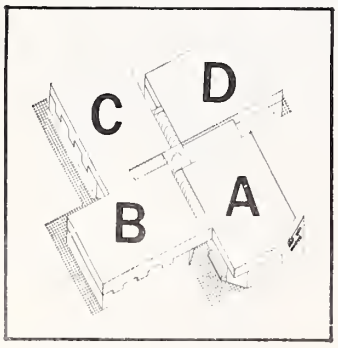
HELFER BROUGHTON INC.

4 World Trade Center
New York, N.Y. 10048

INVESTMENT BANKERS AND SPECIALISTS IN MEDICALLY RELATED NEW ISSUES AND TRADING SECURITIES

STEVEN HIRSCH
Director of Professional Corporations and Fund Management
In New York: (212) 938-1210
Out of State: (800) 221-4188





A—Existing;
B, C, D: Completion 1/30/85

NOW LEASING...

Preconstruction rates. Excellent location with superb facilities.
Adjacent to commercial and residential centers.
Interiors to your specifications with support services desired.
Ownership possibilities. Call Michael Lewis at (609) 235-1661

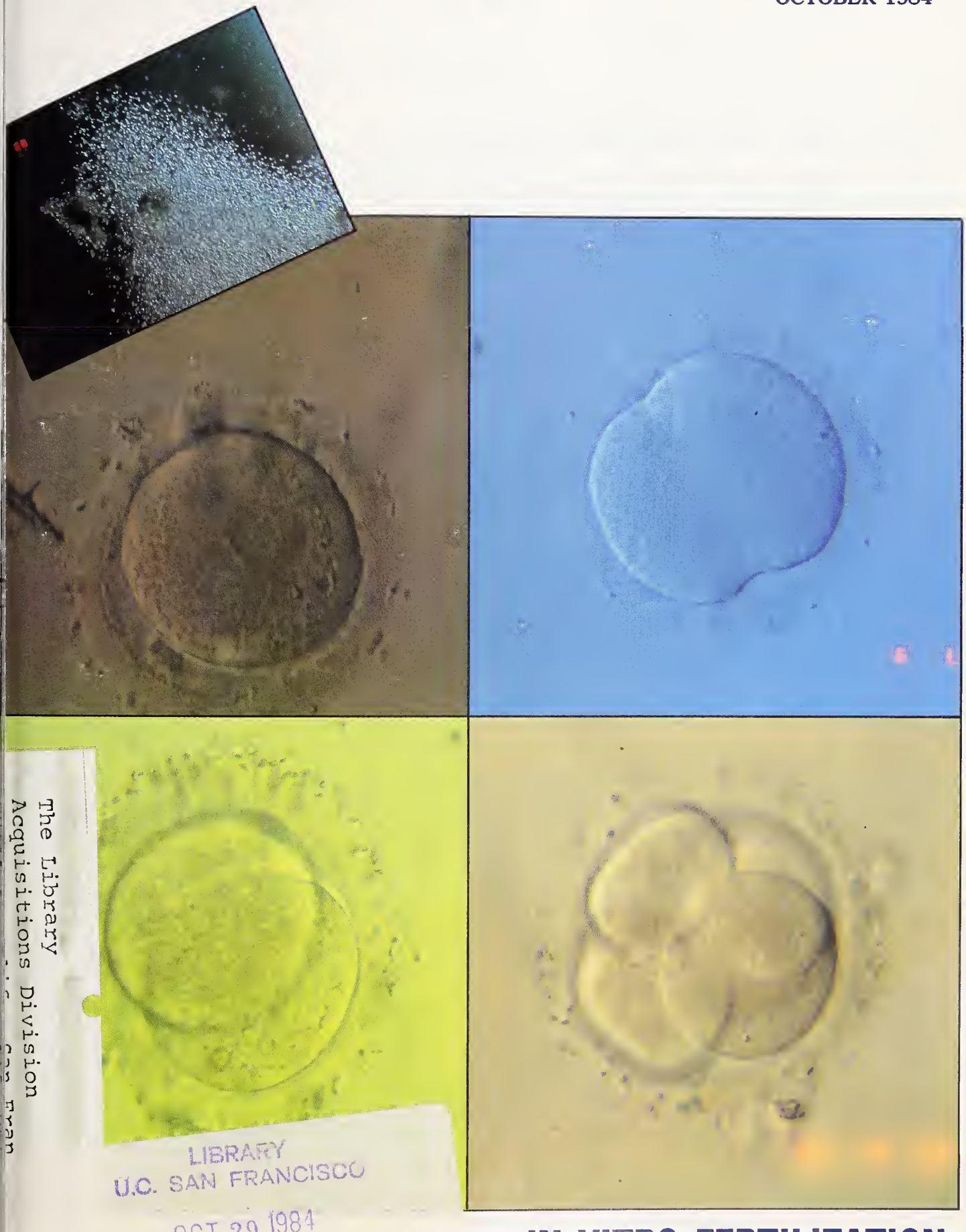
east gate MEDICAL CENTER

Church Street & Gaither Drive
Mount Laurel, New Jersey 08054

THE JOURNAL OF THE MEDICAL SOCIETY OF

NEW JERSEY

OCTOBER 1984



The Library
Acquisitions Division

LIBRARY
U.C. SAN FRANCISCO
OCT 29 1984

IN VITRO FERTILIZATION: THE HUMAN OVUM AT VARIOUS STAGES

E. & W. BLANKSTEEN
E. & W. BLANKSTEEN AGENCY, INC.

ADMINISTRATORS

THE MEDICAL SOCIETY OF NEW JERSEY

ENDORSED PLANS OF:

LONG-TERM INCOME PROTECTION PLAN
MAJOR MEDICAL
OVERHEAD EXPENSE
HOSPITAL-MONEY
6-POINT HIGH LIMIT ACCIDENT
TERM LIFE
KEOGH

NON-GROUP PROGRAMS OF:

HOMEOWNER'S
OFFICE PACKAGE
LIFE
IRA
PENSION

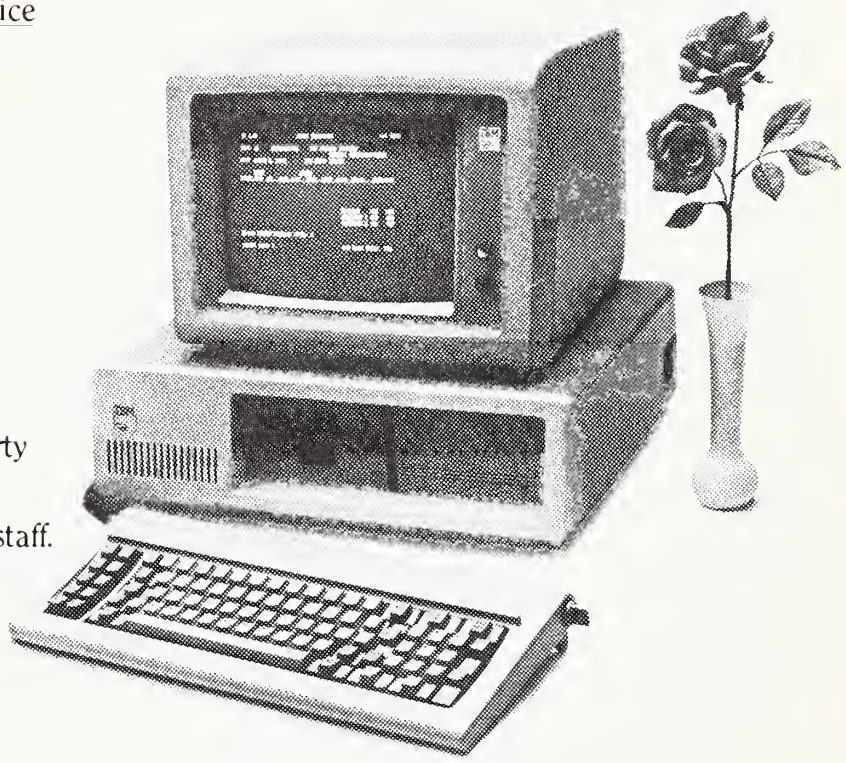
75 Montgomery Street
Jersey City, N.J. 07201
(201) 333-4340 1-(800) BLANK AG

he IBM Personal Computer
tool for modern times
n the Medical Office.

EDI-SCAN®, Authorized IBM® Value-
lded Dealer for the Personal Computer

Comprehensive $8,995.00 MEDI-SCAN In-office
ng And Accounting System Includes:

- he IBM Personal Computer XT with 128K, Megabyte hard disk.
- he IBM Graphics Printer.
- EDI-SCAN software—customized for your actice, including procedure numbers for state encies. Generates accounting reports, mprehensive patient statements, insurance d third party forms.
- otional electronic paperless billing to third party encies, where applicable.
- aining—Complete in-office training for your staff.
- pport—"HOT-LINE" 800 number for ntinuous support.



EDI-SCAN Single Source
pport System

DI-SCAN'S unique, comprehensive hardware and software maintenance agreement guarantees continuing ice and repair, system updates and additional customization, plus in-office training—all from one source. Our l training consultants and technicians are dedicated to giving you the best possible service.

Personal Computer XTs are in stock in our local warehouses ready to be immediately installed. Over five dred physicians are using the MEDI-SCAN System—join them in making the IBM PC-XT "A tool for modern es in the medical office."

Approved nationwide by over 25 third party carriers for electronic claims submission

---

would like to know more about the MEDI-SCAN ystem on the IBM Personal Computer XT.

r._____

ddress_____

ity_____ State_____ Zip____

hone (____)_____

Or call: 800-922-1021
In MA: 800-462-1009

Send to: **MEDI-SCAN**
90 Madison Street, Worcester, MA 01608

IBM Authorized Value Added Dealer Personal Computers

MEDI-SCAN

ervice centers currently in: *New England* · *Mid Atlantic States* · *Mid Western States* · *California* · *Texas*

MEDI-SCAN is a registered trademark of PAL Assoc. Inc.
L Associates is an Authorized IBM Value-Added Dealer for the Personal Computer.
BM is a registered trademark of International Business Machines Corporation.

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

Officers and Trustees

PRESIDENT AND CHAIRMAN OF THE BOARD
Frank Y. Watson, M.D. (Essex) ..... Glen Ridge
PRESIDENT-ELECT
Ralph J. Fioretti, M.D. (Bergen) ..... Rochelle Park
FIRST VICE-PRESIDENT
Edward A. Schauer, M.D. (Monmouth) ..... Farmingdale
SECOND VICE-PRESIDENT
Harry M. Carnes, M.D. (Camden) ..... Audubon
IMMEDIATE PAST-PRESIDENT
Alexander D. Kovacs, M.D. (Union) ..... Scotch Plains
SECRETARY
Arthur Bernstein, M.D. (Essex) ..... South Orange
TREASURER
Paul J. Hirsch, M.D. (Somerset) ..... Bridgewater

Trustees

Joel S. Cherashore, M.D. (1986) (Essex) ..... Nutley
Douglas M. Costabile, M.D. (1987) (Union) ..... Murray Hill
Palma E. Formica, M.D. (1987)
(Middlesex) ..... New Brunswick
Harry W. Fullerton, Jr., M.D. (1985)
(Salem) ..... Carney's Point
Frank Gingerelli, M.D. (1986) (Bergen) ..... Hackensack
Michael M. Heeg, M.D. (1987) (Mercer) ..... Trenton
Louis L. Keeler, M.D. (1985) (Camden) ..... Collingswood
John P. Kengeter, M.D. (1987) (Ocean) ..... Toms River
Edwin W. Messey, M.D. (1985) (Burlington) ..... Willingboro
Myles C. Morrison, Jr., M.D. (1985) (Morris) .... Morristown
John J. Pastore, M.D. (1986) (Cumberland) ..... Vineland
Carl Restivo, Jr., M.D. (1987) (Hudson) ..... Jersey City
Bernard Robins, M.D. (1987) (Essex) ..... Springfield
Gerald H. Rozan, M.D. (1987) (Passaic) ..... Wayne

Councilors

FIRST DISTRICT
(Essex, Morris, Union, and Warren Counties)
Edward M. Coe, M.D. (1987) ..... Cranford
SECOND DISTRICT
(Bergen, Hudson, Passaic, and Sussex Counties)
Robert A. Weinstein, M.D. (1986) ..... Newton
THIRD DISTRICT
(Hunterdon, Mercer, Middlesex, and Somerset Counties)
Louis G. Fares, M.D. (1985) ..... Trenton
FOURTH DISTRICT
(Burlington, Camden, Monmouth, and Ocean Counties)
Frederick W. Durham, M.D. (1987) ..... Haddonfield
FIFTH DISTRICT
(Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties)
Paul H. Steel, M.D. (1986) ..... Atlantic City

AMA Delegates

William J. D'Elia, M.D., *Chairman* (1985) ..... Spring Lake
Alfred A. Alessi, M.D. (1986) ..... Hackensack
Frederick W. Durham, M.D. (1986) ..... Haddonfield
Palma E. Formica, M.D. (1986) ..... New Brunswick
Karl T. Franzoni, M.D. (1986) ..... Trenton
John S. Madara, M.D. (1986) ..... Salem
Henry J. Mineur, M.D. (1986) ..... Cranford
Myles C. Morrison, Jr., M.D. (1985) ..... Morristown
Howard D. Slobodien, M.D. (1985) ..... Metuchen

AMA Trustee

James S. Todd, M.D. (Ridgewood) ..... Bergen

Publication Committee

Paul J. Hirsch, M.D., *Chairman*
Dirck L. Brendlinger, M.D.
Frederick B. Cohen, M.D.
A. Olusegun Fayemi, M.D.
La Verne Fioretti
Robert M. MacMillan, M.D.
Leon G. Smith, M.D.

Editor

Arthur Krosnick, M.D.

Managing Editor

Geraldine R. Hutner

Assistant Managing Editor

Dorothy J. Griffith

Advertising Manager

E. Elizabeth Cookson

Graphic Artist

Frank Cecala

Executive Director

Vincent A. Maressa

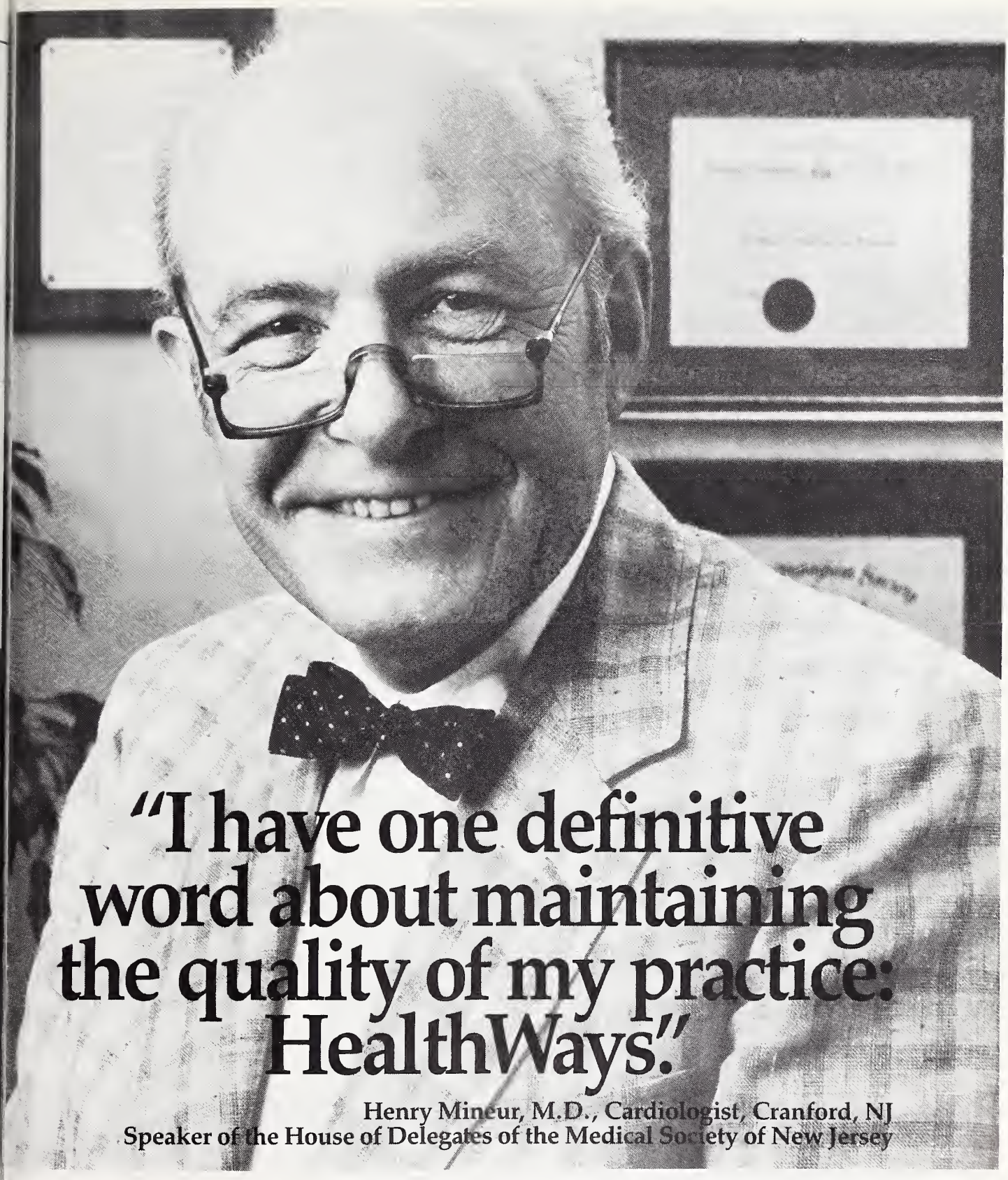
Executive Director Emeritus

Richard I. Nevin

Editorial Board

Jerome Abrams, M.D. (Obstet/Gynecol)
Joseph Alpert, M.D. (Vasc Surg)
Harold Arlen, M.D. (Otolaryngol)
Alfonse Cinotti, M.D. (Ophthalmol)
Robert Dodelson, M.D. (Nephrol)
Norman H. Ertel, M.D. (Int Med/Endocrinol)
Daniel P. Greenfield, M.D. (Psychiat)
Christine E. Haycock, M.D. (Sports Med)
Monroe S. Karetzky, M.D. (Pulmon Med)
Avrum L. Katcher, M.D. (Pediatr)
Stanley C. Leonberg, Jr., M.D. (Neurol)
Joel D. Levinson, M.D. (Gastroenterol)
Joseph A. Lieberman, III, M.D. (Fam Med)
Alan J. Lippman, M.D. (Oncol)
Henry R. Liss, M.D. (Neurosurg)
Geobel A. Marin, M.D. (Int Med/Gastroenterol)
Donald G. McKaba, M.D. (Allergy)
Robby Meijer, M.D. (Plas Surg)
Frank T. Padberg, Jr., M.D. (Surg)
Christopher A. Papa, M.D. (Dermatol)
Edwin L. Rothfeld, M.D. (Cardiol)
Benjamin F. Rush, Jr., M.D. (Surg)
Morris H. Saffron, M.D. (Med His)
Mark M. Singer, M.D. (Int Med/Endocrinol)
Sheldon D. Solomon, M.D. (Rheum)
Lloyd N. Spindell, M.D. (Radiol)
A. Arthur Sugerman, M.D. (Psychiat)
Stephen F. Wang, M.D. (Pediatr)
Edwin S. Wilson, M.D. (Radiol)
Louis S. Zeiger, M.D. (Nucl Med)
Robert B. Zufall, M.D. (Urol)

The Journal of the Medical Society of New Jersey (ISSN-0025-7524) is published monthly (since 1904) exc semimonthly in July (13 issues), under direction of the Committee on Publication, by the Medical Society of N Jersey, Two Princess Road, Lawrenceville, NJ 08648. Printed in East Stroudsburg, PA, by the Hughes Print Co. Whole number of issues 967. Member's subscription ($10) is included in Society dues. Rates for nonmembe $20; outside USA add $7.50 for postage. Single copies, $2. Address communications to *The Journal* MSNJ, T Princess Road, Lawrenceville, NJ 08648, (609) 896-1766. Second-class postage paid at Trenton, NJ, and additio entry office. Copyright 1984 by the Medical Society of New Jersey.



"I have one definitive word about maintaining the quality of my practice: HealthWays."

Henry Mineur, M.D., Cardiologist, Cranford, NJ
Speaker of the House of Delegates of the Medical Society of New Jersey

"Sadly, as the cost of medical care increases and the scope of many health insurance programs decreases, my patients wind up in a terrible squeeze. I found a very satisfactory solution. I became a participating physician in HealthWays.

With HealthWays, I can practice the kind of medicine that will truly benefit my patients without worrying about their financial positions because of the HealthWays unique physician reimbursement policy. That's a significant plus.

In addition, the administrative and financial structure of HealthWays is fighting the astonishing escalation of costs by covering procedures easily done on an out-patient basis rather than in the hospital. That makes a lot of sense. So does their policy of covering routine check-ups. And since the bills go directly to HealthWays, the specter of unpaid bills is eliminated."

HealthWays can be most valuable to your practice too. For more information, call Jon Marsicano, M.D., Vice President, Medical Affairs, at 1-800-624-0720.

HealthWays
YOUR WAY TO BETTER HEALTH CARE

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY
OCTOBER 1

FEATURES

829 Membership Newsletter
837 Professional Liability Commentary
841 Editorials
847 Hospital Governing Boards

CONTRIBUTIONS

849 Initial Experience with In Vitro Fertilization in New Jersey
E. Kemmann, M.D., D. Colburn, M.D., S. Pasquale, M.D., J. Nosher, M.D., V.T. Brandeis, M.D., A.M. Delisi, M.D., R.M. Shelden, M.D., New Brunswick
857 Myth or Fact: Can Women Self-Diagnose Pregnancy?
G.A. Bachmann, M.D., New Brunswick
863 Risks Associated with Post-Traumatic Flashbacks
A. Burstein, M.D., Freehold
867 Midtrimester Amniocentesis for Prenatal Diagnosis
A. Ghiatas, M.D., Long Branch
870 Microsurgical Resection of AV Malformations from Vital Areas of the Brain
O.R. Hubschmann, M.D., and A.J. Krieger, M.D., Newark
875 Effects of AIDS on Various Aspects of Blood Banking
M. Kuriyan, M.D., F. Muschenheim, M.D., C. Bianco, M.D., New Brunswick
878 Androgen-Secreting Ovarian Tumors in Postmenopausal Women
W.B. Ober, M.D., Hackensack
884 Imaging: Magnetic Resonance Imaging (MRI)
K.L. Jewel, M.D., B.I. Loigman, M.D., R.F. Mattern, M.D., S.D. Richman, M.D., C.C. Royer, M.D., C.A. Whelan, M.D., Caldwell
889 Update: Immunizations During Pregnancy
S.R. Preblud, M.D., K.J. Bart, M.D., A.R. Hinman, M.D., Atlanta, GA
891 Commentary: Update of Diagnostic Related Groups
M.E. Johnson, Lawrenceville

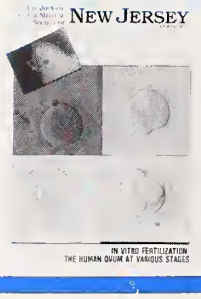
DOCTORS' NOTEBOOK

893 Trustees' Minutes: July 15, 1984
894 UMDNJ Notes, *Stanley S. Bergen, Jr., M.D.*
895 MSNJ Auxiliary, *Grace Gellman*
895 New Members
896 Tamisiea Award
896 Physicians Seeking Location in New Jersey

MSNJ DEPARTMENTS

899 CME Calendar
903 Letters to the Editor
904 Book Reviews
906 Obituaries
908 Information for Authors

On The Cover: The first in vitro fertilization program in New Jersey is underway and the results are in. The complete story on this new method of treating infertility begins on page 849.



Find your doctor is the headline in what has to be one of the largest posters ever produced—three feet by five.

This poster is in fact a directory of the approximately 10,000 Participating P.A.C.E. Physicians and Providers.

Distributed to 10,000 of our larger P.A.C.E subscriber businesses, it has proven to be a unique and effective way to promote participation, and the key role the Participating Doctor plays in this comprehensive health care coverage.

Currently seven out of ten of your colleagues are participating in P.A.C.E.

The P.A.C.E program takes into account the kind of medicine you practice, and where you practice.

P.A.C.E. provides Participating Physicians more equitable and consistant payments.

We actively seek your participation in this unique P.A.C.E. program, for more information please call (201) 456-3200.

The card that you can count on...

Blue Shield
of New Jersey

THE NEW JERSEY ACADEMY OF FAMILY PHYSICIANS

presents its

33rd ANNUAL CONVENTION AND SCIENTIFIC MEETING

March 13-16, 1985

at

HARRAH'S TRUMP PLAZA HOTEL & CASINO ATLANTIC CITY, NEW JERSEY

The Scientific Meeting will include speakers on:

"Cardiology, Infectious Diseases, Dermatology and Sports Medicine" in the Plenary Sessions

and

the Workshops will include sessions on:

"Flexible Sigmoidoscopy, Minor Office Surgery, Basic Casting Techniques and Cardiac Rehabilitation as well as additional subjects of Clinical Importance"

CREDIT HOURS

14 Hours AAFP Prescribed Credit
14 Category I Credits

For Further Information Contact:

Jean M. Winkler
Executive Secretary
New Jersey Academy of Family Physicians
Two Princess Road
Lawrenceville, New Jersey 08648
(609) 896-9130

MEMBERSHIP NEWSLETTER

MSNJ

THE MEDICAL SOCIETY OF NEW JERSEY VOLUME 15

0-DAY LIMITATION ON ALL PRESCRIPTIONS

The Board of Trustees, on January 15 1984, approved a recommendation from the Council on Mental Health, calling for an extension of the 30-day limitation on the filling of prescriptions for controlled substances after the date issued (as proposed in an amendment to N.J.A.C. 8:65-7.5) to include all drugs. This should not affect medications that are taken continuously, such as antibiotics, birth control pills, and diabetic and thyroid drugs, as these prescriptions can be made out to allow a certain number of refills.

To support the forwarding of this recommendation to the New Jersey State Department of Health, the Council on Mental Health is requesting members to submit instances in which they feel prescriptions have been filled after 30 days of issuance which have caused problems in patients, i.e. medications used for conditions other than those for which the prescriptions were written, lack of control of use of medications.

Please forward comments to George L. Triebenbacher, M.D., Chairman, Council on Mental Health, at the Medical Society of New Jersey headquarters.

PSYCHOTHERAPY PROGRESS NOTES

The Division of Medical Assistance and Health Services has submitted a proposed rule concerning the requirements for Psychotherapy Progress Notes to the *New Jersey Register*. The rule describes the essential components of a psychotherapy progress note, including, but not limited to, date and duration of service, name of modality used, notations of treatment results, etc. The full text of the proposal will appear in the *Register*. If there are any problems or questions, contact Henry W. Hardy, Esq., Administrative Practice Officer, (1-609) 292-7079.

GERIATRIC CARE

Every physician has geriatric patients. While many people over the age of 65 remain healthy and active, some have medical problems which require assistance from others. Some of the common problems include: lack of knowledge regarding benefits, entitlements, and the aging process; management of chronic pain; emotional and financial strain; anxiety; depression; guilt; and time management. There are support groups available to help these patients, such as the New Jersey Senior Citizens Hotline, (1-800) 792-8820, and county offices on aging.

FOREIGN MEDICAL GRADUATES

Foreign medical graduates' (FMGs) role in organized medicine was explored at the AMA Ad Hoc Committee Meeting on FMGs, held on September 5, 1984. The purpose of the Committee is to study the problems and special concerns of FMGs, including U.S. citizens who studied in foreign medical schools. One of the expected results is increased involvement of FMGs in organized medicine.

PRESCRIPTION ABUSE

Prescription Abuse Data Synthesis (PADS) project of the AMA has resulted in 11 arrests and 8 convictions in Michigan. Some 41 cases still are under investigation by enforcement agencies participating in a task force for identifying practitioners who prescribe exceptionally high volumes of controlled drugs. The law enforcement agencies, in consultation with the Michigan Medical Society and the Department of Licensing and Regulation, identified the practitioners by coordinating state efforts with computerized federal tracking systems. Michigan authorities said that prescription drugs had been abused or misused by more Americans than cocaine, hallucinogens, or heroin. Most are diverted at the retail level, including physicians' offices, pharmacies, and clinics.

ALTERNATIVE MEDICAL LIABILITY ACT

AMA testified in opposition to H.R. 5400 which establishes an alternative system for settlement of professional liability claims arising from the provision of health care services paid for or provided by federal programs. H.R. 5400 permits a physician or hospital to offer compensation to an injured patient for that patient's "net economic loss" and by so doing foreclose the patient from suits for compensation in the court system. The AMA stated that it is not clear that the bill will reduce any incidences of the practice of "defensive medicine." Rather than reduce aggregate health care costs, the bill is likely to increase them and lead to higher liability premiums. (Subcommittee on Health, House Ways and Means Committee.)

LEGISLATIVE UPDATE

Status of Legislation on Which MSNJ Has Taken an Active Position

Bill	Subject	MSNJ Position	Committee	Present Status
S-70 Codey	To change requirements for eligibility to be Commissioner of Health	Active Opposition	Senate: IHW	In committee
S-111 Bubba	To require a physician to present surgical consent forms at the time surgery is agreed upon	Active Opposition	Senate: LIP	In committee
S-243 Hagedorn	To provide procedures for involuntary civil commitment of the mentally ill	Active Opposition	Senate: IHW	In committee
S-317 Lynch	To provide for regulation of the practice of contact lens dispensing	Active Opposition	Senate: LIP	Withdrawn by sponsor
S-424 Dorsey	To provide for the abolishment of certain state agencies for specific periods of time and to create a Joint Legislative Committee on Regulatory Agencies	Active Support	Senate: SGF&IR&VA	In committee
S-607 Bassano	To require the padding of all metal bars in school buses with energy-absorbing materials to be included in the State Board of Education's rules and regulations	Active Support	Senate: LPS&D	In committee
S-723 Brown	To require the State Department of Health to prepare a booklet on breast cancer and require physicians to give a copy of the booklet to breast cancer patients	Active Opposition	Senate: IHW	In committee
S-752 Hirkala	To provide that certain information of hospitals and long-term health care facility review committees be considered confidential	Active Support	Senate: IHW	In committee
S-754 Hirkala	To provide immunity from civil liability to members of hospital governing bodies in connection with certain review actions taken by them	Active Support	Senate: J	In committee
S-1067 Feldman	To establish and license two categories of social workers	Active Opposition	Senate: IHW	In committee
S-1079 Dumont	Provides for a three-year statute of limitations, except for fraud, intentional concealment, or nontherapeutic or diagnostic purpose. Minors have until age 11 on any injury prior to age 8	Active Support	Senate: J	In committee
S-1112	To establish a cap on the amount of damages which may be awarded for pain and suffering in certain civil actions	Active Support	Senate: J	In committee
S-1135 Dalton	To eliminate certain sources of windfall benefits in personal injury and wrongful death actions	Active Support	Senate: J	In committee
S-1140 Feldman	To impose certain requirements on the plaintiff in a medical malpractice proceeding	Active Support	Senate: J	In committee
S-1182 Saxton	To establish the Automobile Insurance Medical Fee Schedule Board	Active Opposition	Senate: LIP	In committee
S-1190 Feldman	To authorize a court to award reasonable attorney's fees to a party who prevails against a frivolous claim for relief in a civil action	Active Support	Senate: J	In committee

LEGISLATIVE UPDATE

Status of Legislation on Which MSNJ Has Taken an Active Position

Bill	Subject	MSNJ Position	Committee	Present Status
S-1349 Lipman	To require prior patient written authorization before a doctor can perform either a biopsy or mastectomy, or both, in cases of surgery for a breast tumor	Active Opposition	Senate: IHW	Out of committee, amended; 2nd reading
A-115 Otlowski	To authorize optometrists to prescribe a limited number of eye medications	Active Opposition	Assembly: HERP	In committee
A-708	To create a temporary committee to study Diagnosis Related Group System used for setting hospital rates and appropriate $45,000	Active Support	Assembly: CHHS	In committee
A-926 Weidel	To create an Automobile Insurance Fee Schedule Board in the Department of Insurance to adopt a reasonable fee schedule for medical services arising from passenger automobile accidents	Active Opposition	Assembly: BI	In committee
A-960 Miller	To permit individual patients or insurers to appeal hospital bills in cases of assignments under the Diagnosis Related Groups	Active Support	Assembly: CHHS	In committee
A-963 Miller	To eliminate the Diagnosis Related Groups methodology and replace it with one to be devised by the Department of Health in one year	Active Support	Assembly: CHHS	In committee
A-1056 Muziani	To require attending physicians and certified nurse midwives to inform pregnant women of any drugs expected to be used during pregnancy and the possible effects thereof	Active Opposition	Assembly: CHHS	In committee
A-1116 Patero	To permit licensed psychologists to certify disability under the "Temporary Disability Benefits Law"	Active Opposition	Assembly: L	In committee
A-1158 Herman	To require licensed physicians or chiropractors to notify the Board of Medical Examiners if they accept Medicare assignments	Active Opposition	Assembly: HERP	In committee
A-1471 Garvin	To require a physician to obtain, in advance, the patient's authorization to perform a biopsy or mastectomy	Active Opposition	Senate: IHW	Passed Assembly; out of committee; 2nd reading
A-1479 Deverin	To provide for the licensure of podiatric, orthopedic, and urologic x-ray technologists	~~Active Opposition~~ No Action (same as S-515)	Assembly: HERP	In committee
A-1541	To provide for the licensing of persons who practice hypnosis and limit the practice, teaching, or preparation of hypnosis tapes to licensed practitioners	Active Opposition	Assembly: HERP	In committee

Senate Committee Key

IHW:	Institutions, Health and Welfare
J:	Judiciary
LIP:	Labor, Industry and Professions
LPS&D:	Law, Public Safety and Defense
SGF&IR&VA:	State Government, Federal & Interstate Relations & Veterans Affairs

Assembly Committee Key

BI:	Banking and Insurance
CHHS:	Corrections, Health and Human Services
HERP:	Higher Education and Regulated Professions
L:	Labor

Attendance at Board of Trustees' Meetings: County Societies
January 1984-May 1984

Atlantic County
January 15 — Alan J. Simpson, M.D., President
February 19 — Melvin Markowitz, M.D., Executive Committee
March 18 — William Silverman, M.D., Treasurer
April 15 — John C. Baker, M.D., President-Elect
Edwin H. McKnight, M.D.
Mrs. Jo Ann Raco, Executive Director
May 2 — Alan J. Simpson, M.D., President

Bergen County
January 15 — Marc J. Crilly, M.D., President-Elect
February 19 — Marc J. Crilly, M.D., President-Elect
March 18 — Marc J. Crilly, M.D., President-Elect

Camden County
January 15 — August P. Ciell, M.D.
Booth H. Durham, M.D.
Louis L. Keeler, M.D., President
February 19 — Louis L. Keeler, M.D., President
March 18 — August P. Ciell, M.D.
Louis L. Keeler, M.D., President
Donald Orth, M.D.
Joseph A. Riggs, M.D.
April 15 — George T. Hare, M.D.
Joseph A. Riggs, M.D.
Ralph A. Skowron, M.D.
May 2 — Louis L. Keeler, M.D., President

Cumberland County
January 15 — L. Willis Allen, M.D., Past President

Essex County
February 19 — Bernard Robins, M.D.
Carolyn W. Watson, M.D.
March 18 — Carolyn W. Watson, M.D.
April 15 — Carolyn W. Watson, M.D.
May 2 — Mr. Arthur Ellenberger, Executive Secretary
May 6 — Mr. Arthur Ellenberger, Executive Secretary
William Greifinger, M.D.
Carolyn W. Watson, M.D.

Gloucester County
April 15 — Churchill L. Blakey, M.D., Secretary

Hudson County
February 19 — Janet Geraghty-Deutsch, M.D.
Mrs. Adelene F. Lynch, Executive Secretary
April 15 — Joseph W. Fleisher, M.D.
May 2 — Charles L. Cunniff, M.D.

Mercer County
January 15 — Mrs. Joey Huddy, Executive Secretary
Ms. Anne Petchel
February 19 — Mrs. Joey Huddy, Executive Secretary
Ms. Anne Petchel
March 18 — Michael M. Heeg, M.D.
Michael J. Larkin, M.D.
April 15 — Mrs. Joey Huddy, Executive Secretary
Ms. Anne Petchel

Middlesex County
January 15 — Norval F. Kemp, M.D., President-Elect
February 19 — Mrs. Mary Alice Bruno, Executive Director
Norval F. Kemp, M.D., President-Elect
March 18 — Norval F. Kemp, M.D., President-Elect
April 15 — Mrs. Mary Alice Bruno, Executive Director
Norval F. Kemp, M.D., President-Elect
May 2 — Mrs. Mary Alice Bruno, Executive Director
Robert E. Steward, M.D., President
May 6 — Mrs. Mary Alice Bruno, Executive Director

Monmouth County
February 19 — Birute S. Preikstas, M.D.
March 18 — Mrs. Patricia Klemm, Executive Secretary

Morris County
January 15 — Arthur Ginsburg, M.D., President
February 19 — Michael R. Henderson, M.D.
March 18 — Arthur Ginsburg, M.D., President
James B. Massengill, M.D.
April 15 — Allan L. Gardner, M.D., President-Elect
Arthur Ginsburg, M.D., President

Ocean County
January 15 — Michael C. DiBella, M.D., President
Edward D. Fiore, M.D., President-Elect

Passaic County
January 15 — Mr. William T. McGuire, Executive Director
Gerald H. Rozan, M.D., President
February 19 — David J. Blackman, M.D., President-Elect
Gerald H. Rozan, M.D., President
April 15 — David J. Blackman, M.D., President-Elect

Somerset County
February 19 — Albert M. Doswald, M.D., President
April 15 — Albert M. Doswald, M.D., President

Union County
January 15 — Frank R. Romano, M.D., Past President
Mrs. Ethel Stevens, Executive Director
March 18 — Frank R. Romano, M.D., Past President
Mrs. Ethel Stevens, Executive Director
April 15 — Frank R. Romano, M.D., Past President
May 2 — Frank R. Romano, M.D., Past President
Mrs. Ethel Stevens, Executive Director
May 6 — Frank R. Romano, M.D., Past President

Warren County
February 19 — Volmar A. Mereschak, M.D., President

AMA DELEGATES REPORT

Health Policy Agenda. A special reference committee was appointed to consider the 159 principles developed by the Health Policy Agenda for the American people. These principles are broad value statements about what should exist in the health policy area. Instead of adopting the principles as AMA policy, the House voted to endorse them as working principles to help guide AMA representatives to HPA Work Groups and Advisory Committees throughout the remainder of the project, scheduled for completion in 1986. In its next phase, the HPA will translate the principles into policy recommendations and action plans.

Hospital Medical Staff Issues. The Hospital Medical Staff Section met for two days prior to the opening of the AMA House. Over 700 representatives were regis tered from virtually every state. They considered abou 60 resolutions and submitted 18 resolutions for cor sideration by the AMA House. Enthusiasm amon HMSS representatives remains high and participatio in this policymaking process is expected to increas The goal is to have every hospital send a representativ to further enhance communication between the AM and local hospital medical staffs. The AMA House ap proved a number of resolutions related to the organiza tion and operation of the medical staff. The House

- Supported the medical staff's authority to approv or disapprove all amendments to medical staff bylaw
- Supported the idea that hospital governing board cannot unilaterally change medical staff bylaws.
- Asked the AMA to prepare and distribute a docu

Attendance at Board of Trustees' Meetings: Specialty Societies, Academy of Medicine of New Jersey, and Auxiliary January 1984-May 1984

lew Jersey Allergy Society
February 19 Clement Maccia, M.D., President-Elect

lew Jersey State Society of Anesthesiologists
March 18 Stanley Bresticker, M.D.
April 15 Stanley Bresticker, M.D.

lew Jersey Chapter, American College of Emergency Physicians
January 15 Rudolf E. Schwaeble, M.D.
February 19 Rudolf E. Schwaeble, M.D.
March 18 Rudolf E. Schwaeble, M.D.
April 15 Rudolf E. Schwaeble, M.D.
May 6 Rudolf E. Schwaeble, M.D.

lew Jersey Academy of Family Physicians
April 15 S. Thomas Carter, Jr., M.D., President-Elect
Joseph A. Lieberman, III, M.D., Vice-President
Carl F. Meier, M.D.
George L. Triebenbacher, M.D., President
May 2 George L. Triebenbacher, M.D., President
May 6 George L. Triebenbacher, M.D., President

lew Jersey Society of Internal Medicine
February 19 Frank J. Malta, M.D.
March 18 Frank J. Malta, M.D.
May 6 Frank J. Malta, M.D.

lew Jersey Association of Medical Specialty Societies
February 19 Frank J. Malta, M.D., President
March 18 Stanley Bresticker, M.D.
Frank J. Malta, M.D., President
April 15 Stanley Bresticker, M.D.
May 6 Frank J. Malta, M.D., President

lew Jersey Obstetrical and Gynecological Society
January 15 John D. Franzoni, M.D.
February 19 John D. Franzoni, M.D.
April 15 John D. Franzoni, M.D.

New Jersey Academy of Ophthalmology and Otolaryngology
February 19 Edward P. Siegel, M.D.

New Jersey Orthopaedic Society
March 18 Bernard A. Rineberg, M.D.

New Jersey Society of Pathologists
February 19 Lawrence Sylvia, M.D., Vice-President

New Jersey Society of Physical Medicine and Rehabilitation
Feburary 19 Robert Iskowitz, M.D., Member-at-Large

American College of Physicians—New Jersey
February 19 David A. Willard, M.D., Liaison
April 15 David A. Willard, M.D., Liaison

New Jersey Psychiatric Association
January 15 John C. Patterson, M.D., President
February 19 John C. Patterson, M.D., President
March 18 John C. Patterson, M.D., President

New Jersey Rheumatism Association
January 15 William E. Ryan, M.D., Liaison
Feburary 19 William E. Ryan, M.D., Liaison
March 18 William E. Ryan, M.D., Liaison
April 15 William E. Ryan, M.D., Liaison
May 6 William E. Ryan, M.D., Liaison

Academy of Medicine of New Jersey
January 15 Sherman Garrison, M.D.
February 19 Sherman Garrison, M.D.
Mr. Charles J. Heitzmann, Executive Director
March 18 Sherman Garrison, M.D.
May 2 Sherman Garrison, M.D.

Medical Society of New Jersey Auxiliary
January 15 Mrs. Gale Wayman, President
February 19 Mrs. Gale Wayman, President

ent on the legal status of medical staffs.
- Encouraged hospitals and medical staffs to make medical staff rules available to physicians.
- Directed the AMA to oppose any regulation that ould mandate voting privileges for nonphysician embers of the medical staff.
- Recommended that medical staffs develop bylaw ovisions that affirm the binding effect of medical uff bylaws on the hospital governing board and the edical staff.

Professional Liability. On the last day of the meeting, the Board of Trustees submitted a report informng e House that a special task force will be established study professional liability. The task force is charged th coordinating current AMA activities and focusing em on professional liability insurance. AMA Executive Vice-President, James H. Sammons, M.D., will air the task force. Other members include AMA General Counsel, the Assistant Executive Vice-President, d two Deputy Executive Vice-Presidents. The Board ll submit a report at the 1984 Interim Meeting.

MA-HOSPITAL MEDICAL STAFF CTION MEETING

There will be a meeting of the AMA-Hospital Medical aff Section on November 29 to December 3, 1984, at e Hilton Hawaiian Village, Honolulu. The meeting will consist of group sessions, open assembly, and policy deliberations. For more information contact the AMA, Department of Hospital Medical Staff Services, 535 North Dearborn Street, Chicago, IL 60610 or call, (1-312) 645-4747.

LEADERSHIP CONFERENCE

The Women Physicians' Leadership Conference will be held on October 27, 1984, from 8:30 A.M. to 3:00 P.M. at the Medical Education Building, UMDNJ-Rutgers Medical School, New Brunswick. Speakers will present the following subjects: Organizational Skills; Time Management; Working with Professional Colleagues; After a Residency; and Women in Organized Medicine. For reservations, please call (1-609) 896-1766, Ad Hoc Committee on Women Membership, MSNJ.

HOMEBOUND PATIENT CARE

If you have a patient who is homebound with health problems and is medically at risk, The Homebound Communications Program sponsored by the New Jersey Hospital Association, (1-609) 452-9280, may be the answer to your problem. It is a fee for service, 24-hour support network.

DEFICIT REDUCTION ACT

As you may be aware, Congress passed the "Deficit

Reduction Act of 1984," and the President has signed it. Here is a brief summary of provisions in this law important to physicians.

Medicare Fee Freeze. One portion of the Act is entitled the "Medicare and Medicaid Budget Reconciliation Amendments of 1984." If you treat any Medicare beneficiaries at all, its principal effect is to pressure you into entering a participating physician agreement to accept assignment for all services to those patients.

Most of you will want to carefully consider signing the agreement. It would commit you to accept as full payment (80 percent from your Medicare carrier and the 20 percent coinsurance portion) for each procedure or service to any Medicare patient for a year starting October 1, 1984, the lesser of: your 1982 "customary charge" or the 1982 "prevailing charge" in your region for the procedure or service. This is presumably what you had been receiving for the year just ended in June.

The Act provides several penalties for not "signing up" and there is a sort of reward to encourage your participation. First of all, each time a nonparticipating physician "knowingly and willfully" charges a Medicare beneficiary a fee greater than he charged for that procedure or service in the second quarter of 1984 (April 1 through June 30), he will be subject to a fine (up to $2,000 per charge) and to exclusion from the Medicare program until 1989 or later. The effect is to "freeze" your fees to any Medicare beneficiaries you serve.

Secondly, if you do not participate, your "customary charge" will disregard any fee above that of the second quarter of 1984 until at least October 1, 1986.

Finally, a directory will be published of all doctors who agree to participate. The directory will be distributed to all Social Security offices and to senior citizens' organizations and a letter will be sent to all Medicare beneficiaries about the directory. Also, a toll-free phone number will be set up by each Medicare carrier for Medicare beneficiaries to call for names of participating physicians.

Your reward, of sorts, for signing up is that you may increase your fees any time after you become a participant. While the increases would not be collectible for Medicare patients for a year, they would increase your profile for higher Medicare payments starting October 1, 1985. And they would presumably be collectible from non-Medicare patients and insurers in the normal manner.

You need to consider the reduction in your income if you participate, but you also should consider t effect on your standing in your market if you are r publicized as a participant.

In all events, you should note that the customary a prevailing charges, which limit Medicare's payment your procedures and services, are frozen (which h determined what Medicare would pay in the year ju ended, June 30, 1984) until October 1, 1985.

On the basis of our initial study of this Act, c advice to doctors who treat Medicare beneficiaries 1) consider carefully whether or not to sign the parti pation agreement by which you would accept assig ment for all procedures and services you provide Medicare patients; and 2) do not increase your fees Medicare beneficaries until October 1, 1985, abo their second quarter, 1984 level unless you sign su an agreement. The higher charge in mid-July wou apparently be a violation even if you sign the agr ment in August or September when it becomes ava able!

Tax Law Changes. This new Act also contains voluminous portion entitled the "Tax Reform Act 1984." While there are numerous changes affectin wide range of provisions, here is a list of the items most concern to our clients: 1) automobiles' busine write-offs were reduced, but not as adversely as we h expected; 2) home computers' write-offs were limit 3) recordkeeping becomes required for business c duction of automobiles and home computers; cafeteria plans have new rules and will need your tention; 5) tuition benefits for medical and den school faculty may be affected seriously; 6) VEB ("voluntary employees' beneficiary organization probably will lose their appeal; and 7) interest-fr loans from your corporation to you also are seriou affected.

Retirement Plan Project. You should have receiv information about The Health Care Group retireme plans drafted to satisfy the 1984 TEFRA requiremen The fees for these plans are considerably less th "traditional" fees for individually designed plans, a contain all the provisions considered so important professional health care providers. Call their toll-fr number, (1-800) 441-0737, or write to receive mo information and take advantage of this special o portunity.

FINI

"Envy eats nothing but its own heart."

BALANCED CALCIUM CHANNEL BLOCKADE!



CARDIZEM®
(diltiazem HCl)

balances potent coronary vasodilation with a low incidence of side effects

.ow incidence of side effects
:ARDIZEM® (diltiazem HCl) ›roduces an incidence of adverse eactions not greater than that eported with placebo therapy, hus contributing to the patient's ense of well-being.

rdizem is indicated in the treatment of angina pectoris due to ronary artery spasm and in the management of chronic stable ıgina (classic effort-associated angina) in patients who cannot lerate therapy with beta-blockers and/or nitrates or who remain mptomatic despite adequate doses of these agents.

ferences:

Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.

Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

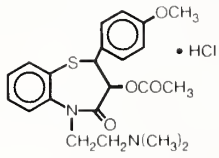
Please see full prescribing information on following page.

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), asthenia (1.2%), AV block (1.1%). In addition, the fol were reported infrequently (less than 1%) with the ord tion corresponding to the relative frequency of occur

Cardiovascular:	Flushing, arrhythmia, hypotens dia, palpitations, congestive syncope.
Nervous System:	Paresthesia, nervousness, tremor, insomnia, hallucinations
Gastrointestinal:	Constipation, dyspepsia, diarr mild elevations of alkaline phosp SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, ph
Other:	Polyuria, nocturia.

The following additional experiences have been nc

A patient with Prinzmetal's angina experiencing vasospastic angina developed periods of transient asystole approximately five hours after receiving a dose of CARDIZEM.

The following postmarketing events have been r quently in patients receiving CARDIZEM: erythema m kopenia; and extreme elevations of alkaline phospl SGPT, LDH, and CPK. However, a definitive cause and these events and CARDIZEM therapy is yet to be est

OVERDOSAGE OR EXAGGERATED RESP

Overdosage experience with oral diltiazem has Single oral doses of 300 mg of CARDIZEM have been by healthy volunteers. In the event of overdosage o response, appropriate supportive measures should b addition to gastric lavage. The following measures may

Bradycardia	Administer atropine (0.60 to 1. is no response to vagal blocka isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia abov degree AV block should be tre diac pacing.
Cardiac Failure	Administer inotropic agents (i dopamine, or dobutamine) and
Hypotension	Vasopressors (eg, dopamine o bitartrate).

Actual treatment and dosage should depend on the clinical situation and the judgment and experience physician.

The oral/LD_{50}'s in mice and rats range from 415 and from 560 to 810 mg/kg, respectively. The intrave these species were 60 and 38 mg/kg, respectively. T dogs is considered to be in excess of 50 mg/kg, whil seen in monkeys at 360 mg/kg. The toxic dose in mar but blood levels in excess of 800 ng/ml have not be with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosc nary Artery Disease or Angina Pectoris at Rest nary Artery Spasm. Dosage must be adjusted to needs. Starting with 30 mg four times daily, before bedtime, dosage should be increased gradually (gi doses three or four times daily) at one- to two-day optimum response is obtained. Although individual respond to any dosage level, the average optimum appears to be 180 to 240 mg/day. There are no available ing dosage requirements in patients with impaired re function. If the drug must be used in such patients, titr carried out with particular caution.

Concomitant Use With Other Antianginal Ag

1. **Sublingual NTG** may be taken as required t anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM coadministered with short- and long-acting nitr have been no controlled studies to evaluate t effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUT

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles 0088-1771-47) and in Unit Dose Identification Paks 0088-1771-49). Each green tablet is engraved with M side and 1771 engraved on the other. CARDIZEM tablets are supplied in bottles of 100 (NDC 0088-1772- Dose Identification Paks of 100 (NDC 0088-1772-4 tablet is engraved with MARION on one side and 177

Another patient benefit product from

PHARMACEUTICAL DIVISION
MARION LABORATORIES, INC.
KANSAS CITY, MISSOURI 64137

The Costs of Medical Care

DRG Care: Estate of Deceased Physician; Informed Consent Medical Suit; Where Litigation Spawns; Did You Know

Prospective pricing for care rendered to Medicare patients in hospitals will heighten lpractice risk, speakers emphasized at a recent rida seminar of the American Hospital Association's ciety for Risk Management. Pressures to reduce gth of stay, cut back on tests, and substitute less ensive diagnostic and therapeutic procedures ld depress existing standards of care, said Monte Jahnke, J.D., of the Detroit firm of Kerr, Russell, and ber. Physicians "have a sense of the standard of care it applies to a given class of treatment," said the troit attorney. "That standard... has been... uni- m: what you did for the average appendectomy pa- nt was pretty well what you do for the next one. But der the DRG/Medicare system, there might be a idency to reduce standards to reflect the extent of vices possible under the new fiscal restraints. That ld create differential expectations between Medi- e and non-Medicare services, stimulating liability k. Wherever you have non-Medicare patients getting e standard of care and Medicare patients receiving haps somewhat less, there is a liability potential." riction between hospitals seeking to discharge pa- nts expeditiously and physicians holding out for a ger length of stay undoubtedly will result, the at- ney said. He noted one case in which a jury awarded 00,000 to a patient whose leg had to be amputated er the utilization review nurse insisted on discharg- her four days earlier than her physician wanted to be released.

Jahnke said that since what a physician writes down as the appropriate diagnosis will determine how much a hospital will get paid under DRGs, the medical record now becomes "the centerpiece for reimbursement." That means the record also becomes even more critical in documenting the care that is given.

Not every suspected coronary patient needs to be placed in an intensive or coronary care bed, where costs are "tremendous," Jahnke admitted, but Michael Azarra, president of Valley Hospital, Ridgewood, pointed out that keeping people out of facilities they don't really need is important, "The flip side... is that if you have guessed wrong, you have got a liability problem." (*Medical Liability Monitor*, Vol. 9, No. 3, March 27, 1984)

PATIENT CAN SUE ESTATE OF DECEASED PHYSICIAN

A deceased physician's estate can be reopened after probate and subjected to a medical malpractice action based on a newly discovered injury, an Oklahoma appellate court ruled.

The patient had extensive gynecological surgery in November 1967. After the surgery, she had kidney trouble and high blood pressure. Her operating physician allegedly made no effort to determine the cause. He died on May 13, 1975. His estate was probated and closed several months later. In October 1978, the patient's condition was diagnosed as a hydronephrotic kidney caused by the improper tying off of the ureter during the 1967 surgery. Removal of the kidney relieved her symptoms.

The patient filed suit to have the physician's estate reopened. A trial court denied her request, but the appellate court reversed. The court noted that an estate could be reopened by a person who had a claim based on a contract if he had a legal excuse for not filing a claim during the original probate of the estate. There was no reason why the malpractice claimant should have less rights since her claim did not arise until after the physician's death, the court said. The fact that there might exist some question concerning the collectability of a judgment in the future does not preclude opening the estate, the court said—Gates *v* Baum, 673 P.2d 519 (Okla. Ct. of App., Sept. 6, 1983; cert. denied, Okla. Sup. Ct., December 13, 1983). (*The Citation*, Vol. 49, No. 4, June 1, 1984)

$1.4 MILLION AWARD IN INFORMED CONSENT MEDICAL SUIT

Ruling that a Bronx woman did not get a clear explanation from her doctor of all the risks of a hysterectomy, a State Supreme Court jury has ordered the doctor to pay her $1,490,500 because he failed to get informed consent, the woman's lawyer said yesterday. The 47-year-old woman contended that an operation performed in 1977 by the defendant physician resulted in the loss of her health and job and made her totally dependent on others. She had worked for the city's

*This item from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse who are, respectively, Director of the Department and Director of Special Projects.

Department of Social Services and was earning $12,500 a year. A Bronx jury of three men and three women said they found no malpractice or professional negligence by the defendant physician, a gynecologist. But they ruled that he had failed to make the plaintiff aware enough of the possible alternatives and outcomes to obtain her informed consent to perform the operation. (*The New York Times*, February 22, 1984)

MALPRACTICE: WHERE LITIGATION SPAWNS

It is no surprise that most medical malpractice actions against physicians stem from incidents in hospitals (Table); only one in five originates in offices. But a current study by a leading liability insurer identifies a new trouble spot: ambulatory surgicenters. Though such claims account for less than 1 percent of those filed, they rank fourth in average cost per claim. (*Medical Economics*, May 28, 1984)

DID YOU KNOW . . .

Two in five doctors surveyed recently by the AMA say they're ordering more diagnostic tests than they did five years ago, and nearly half have increased referrals to other physicians? The AMA estimates that the annual tab for defensive medicine has grown to $15.1 billion, more than the total malpractice judgments against physicians last year. (*Medical Economics*, April 2, 1984)

Florida's physician-owned malpractice insurer suffered a net operating loss of $8.5 million last year, a precipitious drop after the $4.6 million it lost in 1982 and the relatively modest deficit of $113,000 in 1981? As a result, physicians are getting socked with a 30 percent increase in premiums for the third year in a row. The average cost of the cases settled by the insurer in 1983 was a whopping $198,000. (*Medical Economics*, April 2, 1984)

TABLE

*Where Malpractice Claims Are Most Apt to Arise**

Location	Percentage	Average co
Hospital operating room	32.3	$35,324
Physician's office	18.0	25,260
Hospital emergency room	12.3	24,836
Hospital patient-care area	11.8	37,565
Hospital obstetrics units	8.2	64,364
Clinic	7.9	21,053
Hospital—other areas	5.3%	23,685
Hospital outpatient surgery	1.0	14,815
Surgicenters	0.8	29,334
Other locations	2.4	

*Based on claims filed in 1983. Source: St. Paul Fire a Marine Insurance Co.

Insurers in Wisconsin want to increase liabi premiums by an average 50 percent this year? If increases are approved, premiums for neurosurge would jump from $17,295 a year to $25,096; ob/g from $9,431 to $16,730; and gps/fps, the lowest r category, from $1,528 to $2,323 a year? The state me cal society is countering by backing a malpractice form plan that includes sanctions against "repeat fenders," forcing carriers to prepare adequate defen for physicians, a cap on pain and suffering awards, restructuring of award payments, and the eliminat of duplicate compensation. (*Medical Economics*, A 16, 1984)

SNJ Members . . .

e has never been a better time to improve your Keogh and Corporate Retirement Plans

h Care Consulting, Inc. (HCC), primary te of THE HEALTH CARE GROUP, and Medical Society of New Jersey introduce ely program for individually designed ment plans—

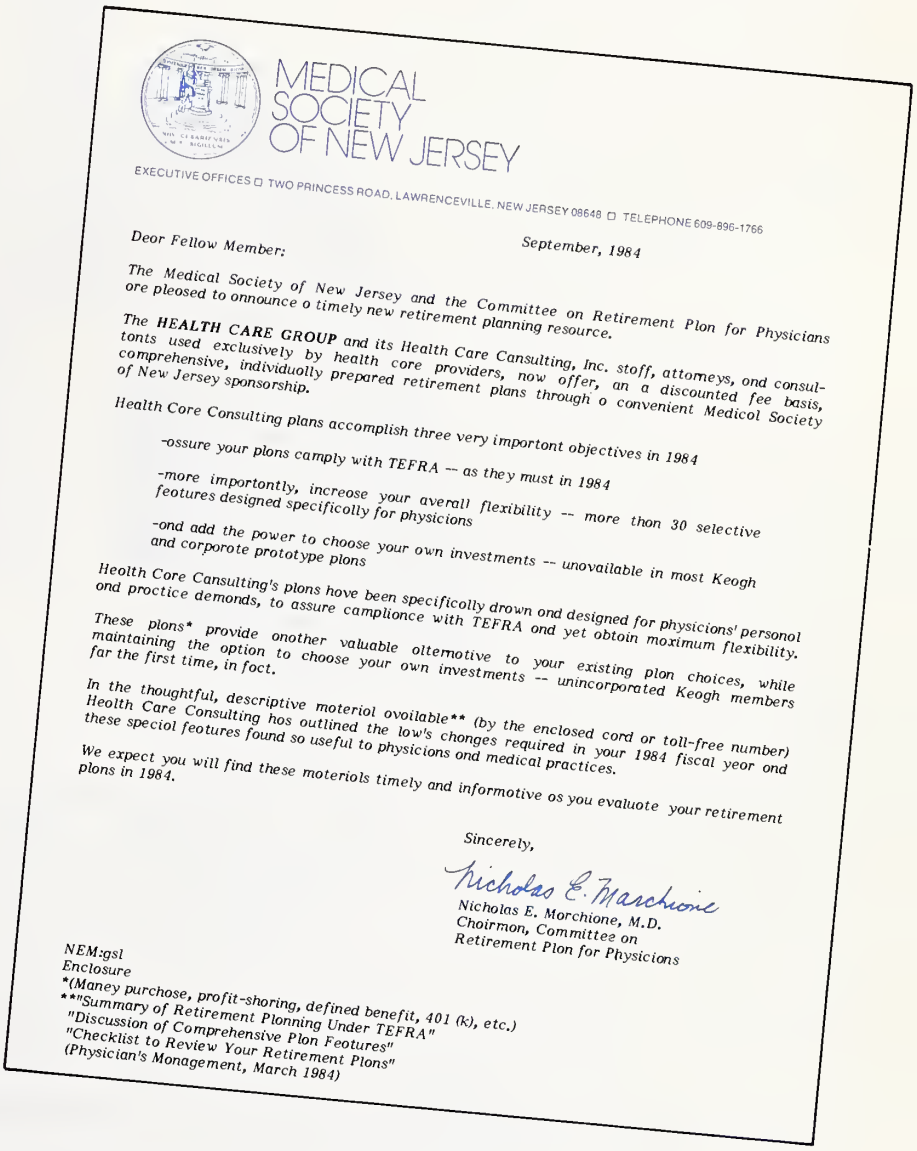
drafted **exclusively** for physicians' practice needs

containing more than 30 **comprehensive,** frequently overlooked features invaluable to medical practices

complying with **TEFRA** as you must in 1984

allowing the same **physicians directed investment** choices for incorporated and unincorporated practices

and providing **innovative Ongoing Plan Service**—accessibility to consultation and advice, routine amendments and our exclusive Retirement Planning Newsletter



MEDICAL SOCIETY OF NEW JERSEY

EXECUTIVE OFFICES ☐ TWO PRINCESS ROAD, LAWRENCEVILLE, NEW JERSEY 08648 ☐ TELEPHONE 609-896-1766

Deor Fellow Member: September, 1984

The Medical Society of New Jersey and the Committee on Retirement Plon for Physicians ore pleosed to onnounce o timely new retirement planning resource.

The **HEALTH CARE GROUP** and its Health Care Consulting, Inc. stoff, attorneys, ond consultonts used exclusively by health core providers, now offer, on a discounted fee basis, comprehensive, individuolly prepared retirement plans through o convenient Medicol Society of New Jersey sponsorship.

Health Core Consulting plans accomplish three very importont objectives in 1984

-ossure your plons comply with TEFRA -- as they must in 1984

-more importontly, increose your overall flexibility -- more thon 30 selective features designed specificolly for physicions

-ond add the power to choose your own investments -- unovailable in most Keogh and corporote prototype plons

Heolth Core Consulting's plons hove been specificolly drown ond designed for physicions' personol ond proctice demonds, to assure complionce with TEFRA ond yet obtoin moximum flexibility.

These plons* provide onother valuable oltemotive to your existing plon choices, while maintaining the option to choose your own investments -- unincorporated Keogh members for the first time, in foct.

In the thoughtful, descriptive moteriol ovoilable** (by the enclosed cord or toll-free number) Heolth Care Consulting hos outlined the low's chonges required in your 1984 fiscal yeor ond these speciol feotures found so useful to physicions ond medical practices.

We expect you will find these moteriols timely and informotive os you evoluote your retirement plons in 1984.

Sincerely,

Nicholas E. Morchione

Nicholas E. Morchione, M.D.
Choirmon, Committee on
Retirement Plon for Physicions

NEM:gsl
Enclosure
*(Maney purchose, profit-shoring, defined benefit, 401 (k), etc.)
**"Summary of Retirement Plonning Under TEFRA"
"Discussion of Comprehensive Plon Feotures"
"Checklist to Review Your Retirement Plons"
(Physician's Monagement, March 1984)

s a pivotal year for retirement planning, with the challenges presented by TEFRA and the rtunity for individually drafted plans.

is extremely pleased to work with MSNJ and has prepared informative material on **ement planning under TEFRA,**" "**comprehensive plan features,**" and a "**checklist to review plans,**" available by phoning toll-free or writing —

Care Group

l Society of New Jersey/
Care Consulting, Inc.
E HEALTH CARE GROUP
lmont Avenue
nwyd, PA 19004
41-0737
7-2468

Name _____

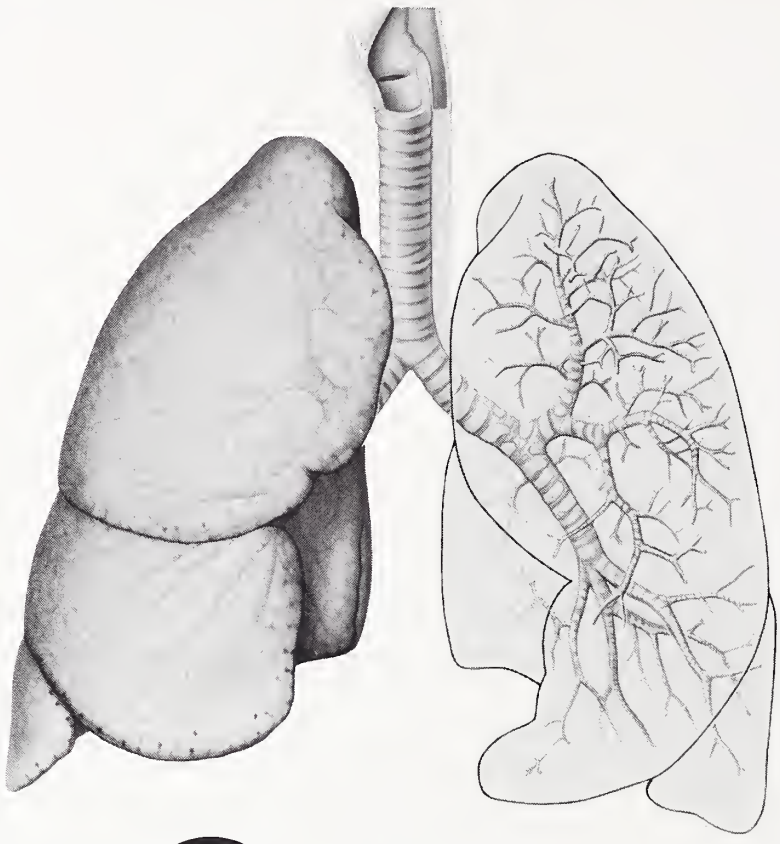
Address _____

_____

Phone _____

Unincorporated ☐ Incorporated ☐ Fiscal year ends _____

Consider the causative organisms...



Ceclor®
cefaclor
250-mg Pulvules® t.i.d.

offers effectiveness against the major causes of bacterial bronchitis

H. influenzae*, *H. influenzae*, *S. pneumoniae*, *S. pyogenes
(ampicillin-susceptible) (ampicillin-resistant)

Brief Summary. Consult the package literature for prescribing information

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — *Pregnancy Category B* — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allerg

Other effects considered related to therapy include eosinophilia (1 in 50 patients) and genital pruritus or (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnorm clinical laboratory test results have been reported. All were of uncertain etiology, they are listed below to su alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alka phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyt predominantly lymphocytosis occurring in infants and children (1 in 40).

Renal — Slight elevations in BUN or serum creatinin 1 in 500) or abnormal urinalysis (less than 1 in 200).

Note. Ceclor* (cefaclor, Lilly) is contraindicated in pa with known allergy to the cephalosporins and should cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatm prevention of streptococcal infections, including the of rheumatic fever. See prescribing information.

© 1984, ELI LILLY AND COMPANY

Additional information available the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

400441

The Rising Cost of Medical Care

The cost of health care has preoccupied individual physicians, organized medicine, government, labor, management, health economists, and patients. This complex issue will be discussed in future editorials.

At their March 18, 1984, meeting, the Board of Trustees approved a recommendation of the Coun- l on Public Relations to direct the Editor of *The ›urnal* to write (or have written) a series of editorials ı that subject which has preoccupied individual phy- :ians, organized medicine, government, labor, man- ement, health economists, and, above all, patients— e cost of health care to the individual and to the ıtion. Grappling with this topic hypothetically and agmatically is a bit like explaining a Jackson Pollock stract painting or a Milton Babbitt composition ısed on the 12-tone musical scale to a group of terested but uninformed sixth graders. Or, it may be tened to the proverbial elephant (health care cost) ing described by six blind men (medicine, govern- ent, consumers, management, labor, and econo- ists) (Figure).

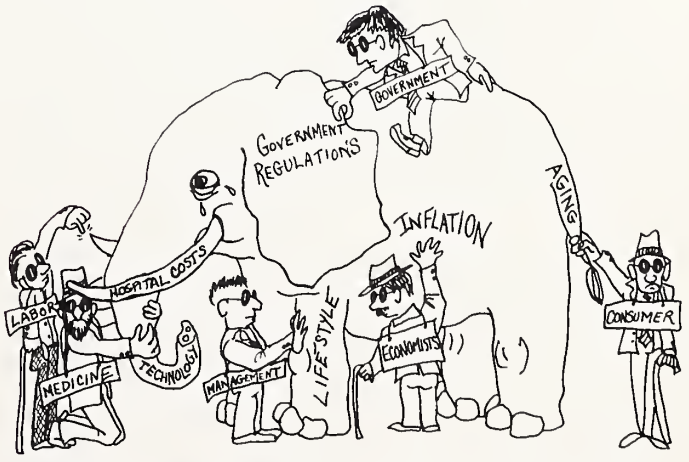
At the outset, one must admit that the subject is mplex and growing. Simplistic solutions such as fix- g physician fees, prospective hospital payment under Diagnosis Related Group (DRG) scheme, rationing of alth care, interdicting the availability and utilization expensive and complex technological equipment, or en a combination of these and other unthought of tions, are not likely to unfurrow the nation's brow. ke the shadow target of the boxer during a condition- g workout, the subject keeps changing, bobbing, and weaving, growing larger and then smaller; the shadowy opponent always stays on his feet until the lights go off. It is unalterably true that the health care cost elephant is not going to go away, and that the six blind men never may be able to "see" the whole beast. Nevertheless, by mandate and in an attempt to be relevant, *The Journal* will take a crack at the subject.

We readily admit that these pieces are being written for the wrong audience. Most physicians will read them and say, "I know that!" and they probably will know "that" and a lot more. The patient—the "consumer" as the economist likes to call him, or the "client" as the social worker says—should be reading these editorials. Short of that, practitioners may organize their ideas and discuss them calmly and rationally with their patients, their friends, their state and national representatives (when possible), and their own providers of goods and services.

Why are medical costs rising? That is not a difficult question to answer, as long as one can provide a long and intertwining answer. Do medical costs differ from the costs of bread, computers, a ticket to the World Series, or a Michael Jackson concert? You're darn tootin' they do!

There are many factors which one can tick off and I intend to do just that, but one I shall not dwell on is fundamental and that is the spirit of freedom of choice. Americans do not like to be told they can't have this, or they must do that. They do not like to queue up for anything (especially left-over cheese that their government is trying to pawn off on them for a few votes). Scientists and biomedical engineers do not want to be told they should not dream up a better mousetrap. Physicians hate being told they must prescribe a generic drug—especially when its pharmacokinetics are unclear. American politicians with coronary artery disease want that quadruple bypass, but grumble that 170,000 such operations were performed last year in the United States at a cost of more than $3 billion. Who is to get the bypass, the organ transplant, the ICU care, the pacemaker, or the hundreds of other expensive treatments, devices, and studies which are commonplace in this America?

The definable contributing forces to health care cost can be considered as a kind of laundry list, which



Figure—The health care cost elephant. Credit: JAK/'84.

obviously needs intensive dissection in future editorials (these will not be listed in order of importance):

1. **Inflation.** Inflation is the reason a good 5¢ cup of coffee now costs 50¢. It is a complex economic subject which U.S. presidents like to blame on previous administrations. It has to do with undue expansion of currency by the issuing of paper money, which governments then like to take back by taxation and borrowing at the expense of future generations. It is associated with runaway prices and runaway credit. Israel's three-figure inflation is among the highest in the world, but high single-digit inflation in the United States is not a comfort to those on fixed incomes, whether they are pensioners or hospitals on DRG.

2. **Technology.** Science and research are the quest for truth. Biomedical engineers, basic scientists, and clinical researchers are bound to make discoveries which enhance the potential for a better life. America is the world frontier for the development of remarkable equipment, pharmaceuticals, and other technological advances—and should remain so.

3. **Government Factors.** The contribution of government dollars to medical and scientific education and research represents a major investment. However, the cost of government regulation of the health industry also is a preponderant part of the nation's health care costs. This cannot be overemphasized.

4. **Consumer Factors.** The patient, as well as the ordinary citizen who simply is growing older, contributes a great deal to the nation's medical costs. Intrinsic diseases, such as diabetes, cause an obligatory expenditure of treatment dollars, but add the factor of lost wages. The cost of drugs and the excessive demand for services are major factors which, to some extent, are patient controlled.

5. **Professional Factors.** The physician has been labeled the "gatekeeper" for health care services, and thus has been identified as a source of the problem of high cost. Fees are obvious, but the peripheral costs which include professional liability expenditures and continuing medical education also must be factored. Not to be forgotten are costs engendered outside the physician's control by paraprofessionals and others

6. **Lifestyle.** It is unquestionable that America modern lifestyle possibly is the largest factor. Tobacc alcohol, and substance abuse, directly and indirectl eat up many billions of dollars. Failure to use aut seatbelts, the simple dominance of the auto and th motorcycle in American life, the sedentary existenc and nutrition abuse leading to obesity must be fa tored in as well.

7. **Psychosocial Factors.** Americans believe they ar entitled to the good life, and this includes good healt Television has shown that the 28-minute cure (leavin time for commercials) should be the norm for mos serious diseases, and much less for ordinary ones. Th roles of stress to the ordinary citizen and the costs c crime (murder, suicide, rape, and physical abuse to se and others) and other psychological and social factor are large.

8. **Hospital, Nursing Home, and Home Care Cost** What do you do with the sick, the elderly, those wh cannot care for themselves, or who need care whic only can be provided in an institutional setting? Th answers are obvious, but that does not mitigate th costs, which are gigantic and growing. Simple, th solution is not—for the hospital is the recipient of th problems engendered by all of the above.

9. **Public Health Costs.** The State Department c Health and Human Services—and their federal healt agency equivalents—are responsible for a great deal c the health dollar expenditure. A close look at thes areas is as essential as all the rest.

So what can be said about health care costs? Is th patient responsible? Yes. Is government responsible Yes. Is the physician the gatekeeper? Yes. Is lifesty a factor? Yes. Is science responsible? Yes. Is inflatio a problem? Absolutely. Are hospitals, nursing home and psychological and social factors contributory? Ce tainly.

We will explore each of these areas, which has bee touched on ever so briefly, in future editorials. In th meantime, as the man used to say, don't touch tha dial!

A.I

Dr. John F. Kustrup 1907-1984

John Francis Kustrup, Sr., M.D., was the 176th president of the Medicial Society of New Jersey. He died on July 5, 1984.

We have lost a fine surgeon, a concerned and caring physician, a humanitarian, and a good nd. John Kustrup was a household name among arge segment of Mercer County and central New sey residents who were his devoted patients, and o spoke of him with near-reverence.

soft voice, a contagious smile, a gentle good humor, l twinkling eyes were his trademarks. Colleagues ke with great respect and affection for John strup.

orn in Trenton in 1907, John studied medicine at rgetown University Medical School and graduated 930. He interned at St. Francis Hospital where he r served as director and chief of surgery. He fulfilled rgical residency at the Delaware Memorial Hospi- Wilmington, and did graduate work at the Gradu- School of Medicine, University of Pennsylvania.

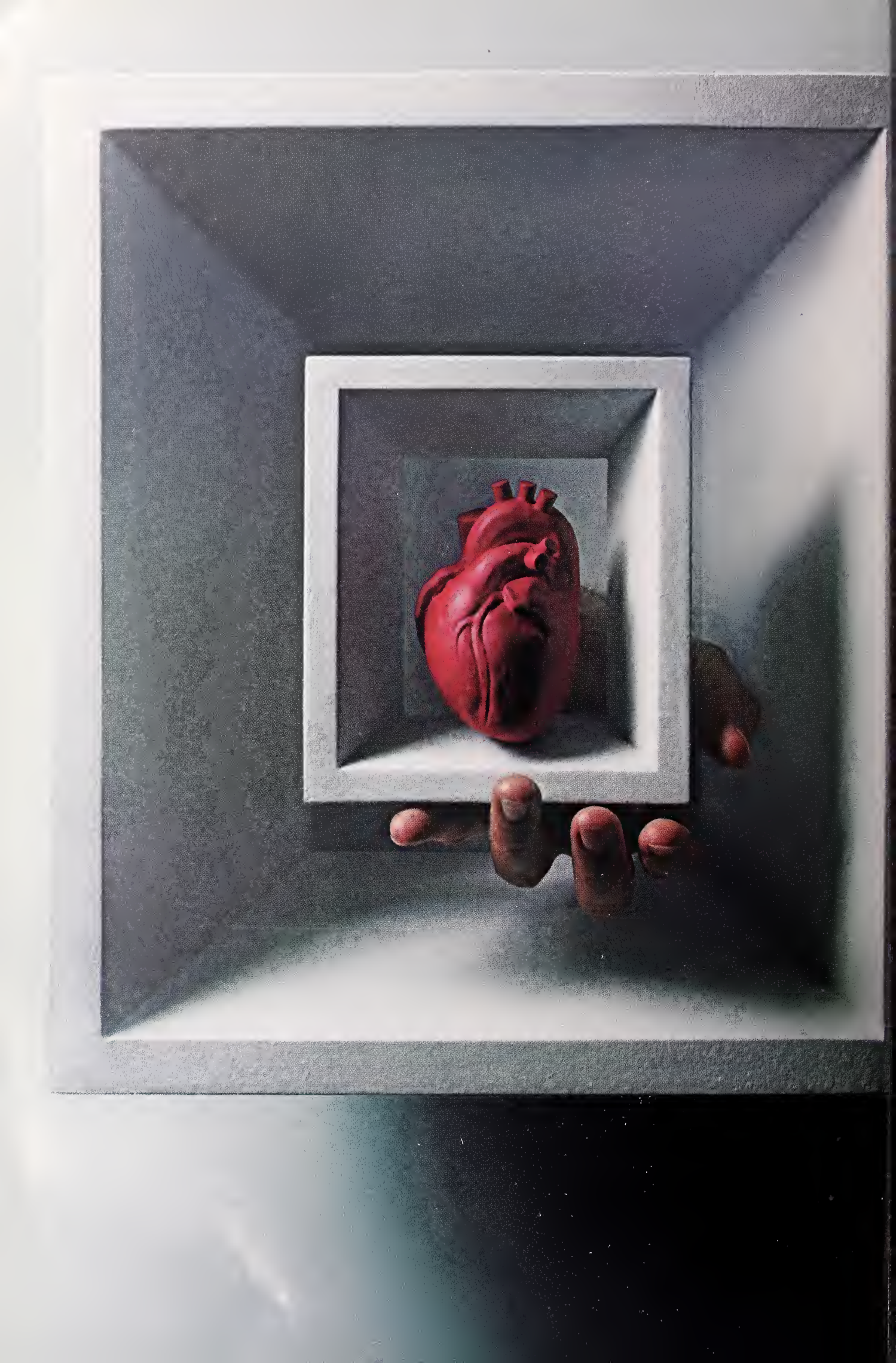
t his peak, Dr. Kustrup was elected President of NJ in 1968, after having served the Mercer County lical Society, the Medical Society of New Jersey, and the AMA in numerous important capacities including Fellow, Officer, and AMA Delegate. His professional accomplishments included fellowship in the American College of Surgeons and the International College of Surgeons, and multiple hospital appointments.

Dr. Kustrup enjoyed telling anecdotes about himself and his local colleagues who competed for house calls in the impecunious days of the Depression, which were so difficult for new medical graduates. His greatest prides were his two sons, John F. Kustrup, Jr., a surgeon, and William J. Kustrup, an ophthalmologist, both of whom are active members of the Mercer County and State Medical Societies.

John F. Kustrup is survived by his wife, the former Eva H. Williams, his daughter, Elizabeth Kustrup Sheahan, and his two sons. He was honored with MSNJ's Golden Merit Award for 50 years of medical service to his community in 1980.

Fine physicians like John F. Kustrup do not die, for they live on in the hearts of those they leave behind.

A.K.



Angina Protection with Benefits for a Lifetime

ONCE-DAILY CONTROL WITH HEART-SAVING BENEFITS

By reducing heart rate and cardiac contractility, INDERAL LA helps protect the heart from the potentially serious and debilitating consequences of ischemia. A highly effective antianginal agent for around-the-clock control of symptoms, INDERAL LA also provides cardiovascular protection for a sense of security in the years ahead.

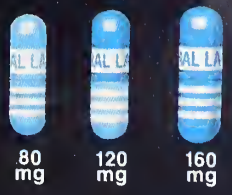
PROTECTION AND EXPERIENCE NO CALCIUM BLOCKER CAN MATCH

Unlike calcium blockers, INDERAL LA—either alone or with a nitrate—is recommended for early treatment of angina in the majority of patients. Equally important, INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use.

START WITH 80 MG ONCE DAILY

Dosage may be increased to 160 mg once daily, as needed, to achieve optimal control. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY **INDERAL LA** (PROPRANOLOL HCl) LONG ACTING CAPSULES



Ayerst®

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

JUST ONCE EACH DAY FOR SIMPLIFIED CORE THERAPY IN ANGINA

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL™ LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking t prior to major surgery is controversial. It should be noted, however, that the impaired a the heart to respond to reflex adrenergic stimuli may augment the risks of general ane and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor o receptor agonists and its effects can be reversed by administration of such agent dobutamine or isoproterenol. However, such patients may be subject to protracted hypotension. Difficulty in starting and maintaining the heartbeat has also been reporte beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent t pearance of certain premonitory signs and symptoms (pulse rate and pressure chan acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may b difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyro Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of sym of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid functio

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have reported in which, after propranolol, the tachycardia was replaced by a severe brady requiring a demand pacemaker. In one case this resulted after an initial dose of propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with im hepatic or renal function. INDERAL is not indicated for the treatment of hypert emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. P should be told that INDERAL may interfere with the glaucoma screening test. Withdraw lead to a return of increased intraocular pressure.

Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart di elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as pine should be closely observed if INDERAL is administered. The added catechola blocking action may produce an excessive reduction of resting sympathetic nervous a which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orth hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animal been conducted to evaluate toxic effects and carcinogenic potential. In 18-month stud both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of signi drug-induced toxicity. There were no drug-related tumorigenic effects at any of the d levels. Reproductive studies in animals did not show any impairment of fertility tha attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryoto animal studies at doses about 10 times greater than the maximum recommended human There are no adequate and well-controlled studies in pregnant women. INDERAL s be used during pregnancy only if the potential benefit justifies the potential risk to the

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block, tension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insc lassitude, weakness, fatigue; reversible mental depression progressing to catatonia, disturbances; hallucinations; an acute reversible syndrome characterized by disorientat time and place, short-term memory loss, emotional lability, slightly clouded sensorium decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, dia constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with a and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocyto purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male tence, and Peyronie's disease have been reported rarely. Oculomucocutaneous rea involving the skin, serous membranes and conjunctivae reported for a beta blocker (prac have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochlorid sustained-release capsule for administration once daily. If patients are switched from IND tablets to INDERAL LA capsules, care should be taken to assure that the desired therap effect is maintained. INDERAL LA should not be considered a simple mg for mg substitu INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitratio be necessary especially to maintain effectiveness at the end of the 24-hour dosing int

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 8 INDERAL LA once daily, whether used alone or added to a diuretic. The dosage ma increased to 120 mg once daily or higher until adequate blood-pressure control is achi The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage mg may be required. The time needed for full hypertensive response to a given dosa variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERA once daily, dosage should be gradually increased at three to seven day intervals until opt response is obtained. Although individual patients may respond at any dosage leve average optimum dosage appears to be 160 mg once daily. In angina pectoris, the valu safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few w (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERA once daily. The usual effective dose range is 160-240 mg once daily. The dosage ma increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response obtained within four to six weeks after reaching the maximum dose, INDERAL LA th should be discontinued. It may be advisable to withdraw the drug gradually over a per several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily
PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group a limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laborat

8833

Ayerst® AYERST LABORATORIES
New York, N.Y. 10017

OSPITAL GOVERNING
OARDS*

Hospital Medical Staffs and Their Retention of Separate Legal Counsel

INCENT A. MARESSA, J.D.

he AMA and MSNJ have recommended that ospital medical staffs should retain legal ounsel separate and distinct from that etained by the hospital governing board.

The American Medical Association and the Medical Society of New Jersey have recommended t hospital medical staffs should retain legal counsel arate and distinct from that retained by the hospigoverning board.

awyers representing hospitals have opposed this cept arguing that the medical staff simply is an anizational extension of the governing board; and t, consequently, there is no separate or self-governmedical staff. That position is not sound and does withstand scrutiny. It is clear that the medical staff st be organized so as to be separate from the gov- ing board. The Joint Commission on Accreditation ospitals (JCAH) standards, Medicare and Medicaid ulations, and hospital licensing laws in New Jersey equire that the medical staff be organized separ- y.

nother frequently raised issue is that a separate lical staff means increased corporate and tort lia- y and potential for greater antitrust exposure. ther the staff is separate or not, its members per- ally will be liable only to the extent that they partici- in wrongful conduct. Hospitals gain no advantage from treating the medical staff as a nonentity. The antitrust rule of reason concept, which would be the general rule of law applied, would involve a study of the particular circumstances in each case, and not whether or not there is a separate organized staff.

Legal ethics require the attorney to present his client's point of view as best he can. Since the medical staff and the governing board can have a divergent position on any issue, separate counsel is not only desirable, it is necessary. Retention of separate counsel is not at all inconsistent with the mutual commitment of the staff and governing board to quality care. Telling medical staffs they cannot consult and retain separate counsel is not legally sound, ignores reality, and promotes confrontation. Governing boards and medical staffs should recognize their unique and common responsibilities in providing the best care they can. They also should appreciate the necessity of adequate and separate legal representation in the discharge of those responsibilities.

*The material for this column is edited by Arthur Krosnick, M.D., Editor of *The Journal*; Vincent Maressa, J.D., Executive Director of MSNJ; and James E. George, M.D., J.D., Director of the Department of Professional Liability.



The Easy Alternative...

Lease the car of your choice from us. You choose the model, color and options ... we do the rest! Our leasing program can be custom-tailored to include insurance, if you desire. We feature personalized service and the extra attention to detail you're looking for.

Call us today at (201) 257-2300 or (212) 964-0037 to lease YOUR car ... the convenient, easy way.

RUTGERS LEASING inc.

6 Connerty Court • East Brunswick, NJ 08816

Note: If you're new to medical practice in N.J. . . .

You don't have to buy commercial malpractice insurance

JAMES S. TODD, M.D., *Chairman/Board of Directors, Medical Inter-Insurance Exchange of New Jersey*

AS you made your decision to establish yourself in New Jersey, you no doubt heard horror stories about our professional liability insurance problems. The legal risks we assume in this business have grown so far out of proportion that many commercial underwriters have been simply unable to cope, resulting in abrupt and often untimely suspension of coverage.

As a new practitioner in this State, either relocating or just beginning your professional career, you have an alternative to commercial insurance. The Medical Inter-Insurance Exchange provides an opportunity to build your new practice on the most secure footing possible with long-term peace of mind.

Founded in 1977 at the peak of the "premium crisis," the Exchange is a wholly doctor-owned cooperative organization through which we insure *ourselves* for our own sake. Membership has grown to two-thi of all practicing physicians and surgeons in t state. Because we're in it for security — *not for profit* — we can provide for ourselves t absolute best available insurance product fo the money. Every dollar we take in goes tow protection (no sales commissions) and every dollar left over is returned to us — in cash.

You owe it to yourself to know your options and the practicalities of each. We're here to help you sort them all out. Call and talk directly to our Vice President and Direc of Policyholder Services, Bill Reilly, **TOLL FREE (in N.J.) 800-257-6288** or (609) 896-2404 from other areas. We look forward to hearing from you.

A professional service message from the **Medical Inter-Insurance Exchange** of N.J.
Two Princess Road, Lawrenceville NJ 08648
(609) 896-2404

Initial Experience with In Vitro Fertilization in New Jersey

E. Kemmann, M.D., D. Colburn, M.D., S. Pasquale, M.D., J. Nosher, M.D., V.T. Brandeis, M.D., A.M. Delisi, M.D., R.M. Shelden, M.D., New Brunswick*

In vitro fertilization is a new method in the management of previously untreatable infertility situations. The first program in New Jersey became operational in 1983. Organization, patient selection, procedures, and initial results of the early experience of in vitro fertilization are described.

Louise Brown, born in England on July 25, 1978, was the first child conceived after fertilization of the oocyte outside of her mother's body.[1] Subsequently, the technology of in vitro fertilization (IVF) rapidly evolved and expanded. The first IVF program in the United States was initiated amidst controversy in Norfolk, Virginia. The first pregnancy in the Norfolk program occurred in April 1981, and completed successfully in December 1981.[2,3] At the annual meeting of the American Fertility Society in the spring of 1982, the investigators from the Norfolk program, as well as a few physicians who had started programs elsewhere, reported their initial experiences. Thus, it was apparent the stage had been set to make the introduction of IVF possible on a wider scale.

Because of our own experience in the use of gonadotropins, laparoscopy, and tissue culturing, we surmised that IVF was feasible at our institution, and would be useful for our patients.

During 1982, the program protocol was developed and approval of the Committee on Human Research was obtained; financial and logistical questions were resolved, and members of the team attended an IVF workshop in Norfolk.[4] Early in 1983 construction of an IVF-culture room was completed and the room equipped. The program officially opened in May 1983. The following is a report on the IVF experience during the remainder of 1983. The IVF program at UMDNJ-Rutgers Medical School, Middlesex General-University Hospital is the first and only program with known pregnancies in New Jersey.

MATERIAL AND METHODS

Referred or interested patients are telephone screened and placed on a list from which they are given appointments to the screening clinic. In the screening clinic, the fertility situation is evaluated, and the couple is presented with an explanation of the procedures involved. Further workup (if necessary) will be done in the screening clinic before admission to the active program. Patients with inappropriate indication for IVF will be so advised. In the screening clinic the couple will meet at least one of the physicians of the program as well as the program coordinator.

As the couple approaches the active phase of the program, the coordinator provides further explanation and support as needed. The coordinator leads the couple through each phase of the program. An informed consent is signed before entering the active phase.

PATIENT SELECTION

Between May and November 1983, 27 patients were

*From the Departments of Obstetrics and Gynecology and Radiology, UMDNJ-Rutgers Medical School. Correspondence may be addressed to Dr. Kemmann, UMDNJ-Rutgers Medical School, Academic Health Science Center, CN 19, New Brunswick, NJ 08903.

TABLE 1

Patient Profile of 27 Women Started in Active Treatment Phase

- Married
- Tubal infertility (post-tuboplasty/ectopic)
- Age: range, 24 to 37; mean, 32
- Infertility: range, 35-10 years; mean, 5.5
- Male: normal semen analysis

entered into the active treatment program. Their ages ranged from 24 to 37 (mean 32) years, and all women had infertility due to absent or chronically damaged tubes. Other criteria for patient selection were: 1) married infertile women with no contraindication to IVF and pregnancy; 2) age less than 38 years; and 3) acceptable semen analysis of husband (>15 x 10^6 sperm/ml, motility > 40 percent, morphology > 40 percent normal) (Table 1).

All patients had previous pelvic surgery. Screening laparoscopies generally were not done, but the patients either agreed or disagreed beforehand to possible laparotomy if laparoscopy could not secure ovarian access. Normal ovulation was not a prerequisite of inclusion.

TREATMENT

Induction of Ovulation. Initially, we used human menopausal gonadotropin (hMG) alone for follicular stimulation, but later adopted a combination regimen of clomiphene citrate, 50 mg daily, day 2 to 6 po, combined with hMG 75 I.U. intramuscularly daily (Figure 1). Thus, the first part of the induction phase was fixed. After day 6, daily hMG was continued on an individually adjusted basis (variable part of induction phase). During this regimen, serum estradiol levels (E2) and pelvic sonograms were obtained daily or every other day to monitor follicular growth. Once the most advanced follicle reached 16 to 18 mm in diameter, and two or more follicles were present, hMG administration was discontinued and 24 to 36 hours later 5,000 I.U. of human chorionic gonadotropin (hCG) were given intramuscularly. Patients with more than two follicles of at least 16 mm size and without significant serum E2 decline prior to hCG administration were scheduled for laparoscopy about 34 hours after hCG administration (range 28 to 36).

While the wife was receiving hMG, the husband was treated with doxycilline 100 mg daily to reduce the possible effect of genitourinary infections on the in vitro ovum cultures later.

Laparoscopy. Laparoscopy usually was performed in the morning, using standard technique with CO_2 insufflation under general anesthesia. Follicles were aspirated using a Norfolk aspirating needle (12 gauge) through the operating channel of a 10 mm Wolf laparoscope. Through a second puncture, a grasping forceps was placed to stabilize the ovary. The follicular aspirates were collected in a culture tube trap (Falcon, #2003, 12 x 75mm) connected to the aspirating needle via Teflon tubing through a silicone stopper. Suction was controlled by means of a finger valve attached to the aspiration needle and vacuum provided from continuous wall suction at 100 to 120 mm Hg; it w controlled by the operator. In general, after aspirati the follicular fluid, the follicle was flushed and, sep ately, the needle was rinsed using Dulbecco's PBS so tion. Each specimen was transferred immediately personnel in the adjacent IVF-culture room.

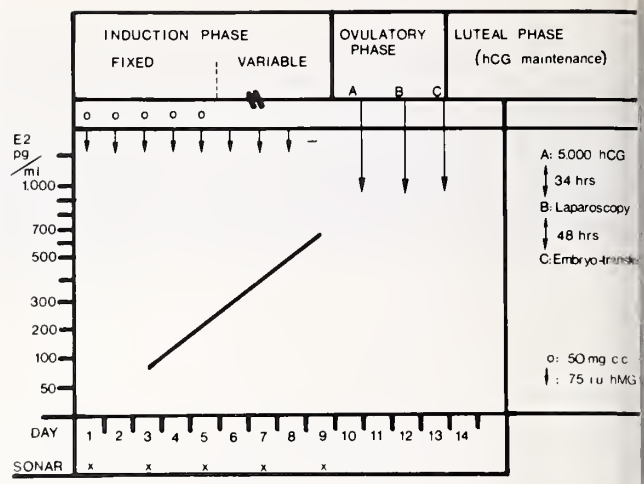
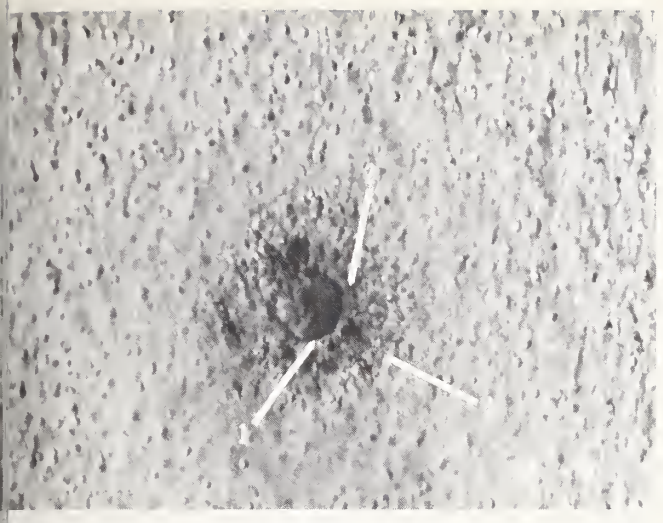


Figure 1—Scheme of treatment regimen. Medication consi of 50 mg/day of clomiphene citrate for five days (circles) a 75 I.U. hMG/day for variable time (small arrows). hMG d may be modified according to estrogen response.

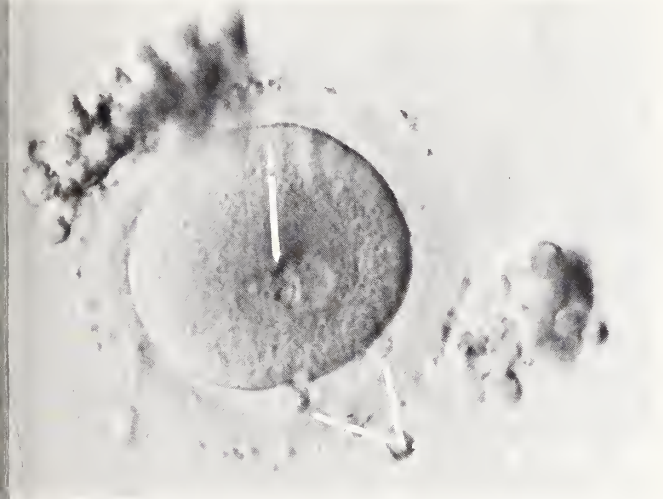
Embryo Recovery, Fertilization, and Culture. E bryo culture procedures essentially were as describ for the Norfolk program with minor modification Stock Hams F-10 media (GIBCO, cat #430-1200) w prepared by dissolving 9.1 gm F-10 powder in 5 redistilled, ultrapure (0.2 micron filter) water, addi sodium bicarbonate (2.1 g, 25 mM), calcium lacta (0.245 g, 0.9 mM), and penicillin G (75 mg/1). We c not use streptomycin in our culture media. Aft equilibration with 5 percent CO_2 in air (USP) for to 15 minutes, the stock solution was adjusted to p 7.35-7.40 with HC1 or NaOH; osmolality was adjust to 280 mmoles/kg, and filter sterilized (0.2 micro Culture media were stored up to two weeks at 4°

Patient serum was obtained after administration hCG during the ovulation induction phase and dea tivated at 58°C for 30 minutes. Culture medium (Har F-10) was brought to 37°C, equilibrated with 5 perce CO_2, and supplemented with 7.5 percent deactivat serum for insemination medium (IM), and 15 perce serum for growth medium (GM). After supplement tion, pH and osmolality were checked and readjust as needed, then resterilized with 0.2 micron filter. I semination medium, 2.0 ml per dish, was aliquoted an appropriate number of culture dishes (Falc #3037) and allowed to equilibrate in the incubator f 16 to 20 hours prior to laparoscopy. Growth mediu was similarly aliquoted and equilibrated after recove of oocytes at laparoscopy.

For instrument rinse, follicular wash, and follicul fluid dilution, we used Dulbecco's phosphate buffer saline (GIBCO, cat #450-1300). DPBS was prepared per manufacturer's recommendations with addition 0.1 g calcium chloride and 75 mg penicillin G, adjust to pH 7.4 at 37°C, and 280 mmoles/kg, then stored 4°C. Prior to laparoscopy, DPBS was supplement with 10 to 15 units/ml sodium heparin, aseptical loaded into syringes for follicular flushing, and allowe to equilibrate at 40 to 45°C (ambient CO_2 atmospher



ure 2A—Mature ovum. Note radial orientation of coronal
ls adjacent to zona pellucida (1), with expanded, mucified
a peripheral to corona (2), and the enlarged, but more
nsely arranged cumulus cells on the periphery (3). Approx-
ately 160 x after photographic enlargement.



ure 2B—Fertilized ovum 18.5 hours postinsemination.
nuclei are juxtaposed, but fusion (syngamy) has not oc-
red (1). Note primary and secondary polar bodies in the
ivitelline space (2). Approximately 900 x after photo-
phic enlargement.

Upon aspiration of the follicular contents, the trap
s removed, capped, and handed directly to culture
sonnel in the adjacent culture facility. Time of
iration was noted and the aspirate volume was ap-
ximated by comparison with a previously calibrated
e. Contents of the trap immediately were decanted
o a warmed (38°C) culture dish (Falcon #3002) and
ner examined immediately or temporarily placed in
umidified 37°C incubator if examination was de-
ed more than one to two minutes. The aspirate was
mined at 10 to 40 x and oocytes immediately were
nsferred via siliconized Pasteur pipet from the
icular aspirate or wash to insemination medium
l placed in the culture incubator (5 percent CO_2 in
37.3° C, 98 percent RH). Detailed examination of
oocyte was postponed until all follicular aspirates
l washings had been examined thoroughly and any
litional oocytes transferred to insemination me-
m.

Each oocyte was examined and classified as 1)
ovulatory (expanded cumulus and corona, Figure
; 2) intermediate (expanded cumulus with compact



Figure 2C—Six-cell embryo (only three blastomeres in focus) 48 hours postinsemination. Approximately 900 x after photographic enlargement.

corona); 3) immature (compact cumulus and corona); or 4) atretic (absence of cellular vestments and/or distorted, discolored, or fragmented ooplasm). Although this examination was subjective and often incomplete due to poor visualization of the oocyte through the surrounding cell vestments, no attempt was made at this stage to remove covering cells in order to enhance visualization.

After classification of the recovered oocyte, the husband was asked to deliver a semen specimen. Semen (1 ml) was diluted with insemination medium (2 ml) then centrifuged at approximately 225 x g for 10 minutes at room temperature. The supernatant was discarded, the pellet resuspended in 2 ml fresh insemination medium recentrifuged as above, and the second supernatant fluid removed. Without disturbing the sperm cell pellet, 1 ml of insemination medium was overlayered, and the tube placed nearly horizontal in the CO_2 incubator. During the ensuing incubation, the sperm cell pellet settled out of the tube tip and spread over the lower tube wall, forming a large surface area for "escape" by active spermatozoa. After 60 to 90 minutes, the insemination medium with active sperm was collected without disturbing any residual pellet. Sperm motility and density were determined, and aliquotes of the washed sperm preparation diluted as needed with insemination medium. Typically, these sperm preparations demonstrated greater than the 90 percent motility, even when initial motility was less than 40 percent. Recovered spermatozoa could be maintained under these culture conditions at least 48 hours without discernible decrease in motility.

Following 6 to 8 hours preincubation (up to 24 hours for immature oocytes), approximately 2 x 10^5 motile sperm in 50 to 100 μl insemination medium were placed with each oocyte. The oocytes were incubated with sperm for 12 to 16 hours, then transferred to 2 ml of growth medium previously equilibrated for at least 14 hours. At this time, embryos were examined for polar bodies and pronuclei, the presence of 2 pronuclei being taken as presumptive evidence of normal sperm penetration (Figure 2B). Subsequently, embryos were examined daily to assess cleavage and development.

Embryo Transfer. Embryo transfer and followup

were scheduled 48 to 60 hours after insemination. The average time between laparoscopy and transfer was 56 hours. At this point successfully fertilized oocytes consisted of four or more cells (Figure 2C). All transfers were performed on an outpatient basis without anesthesia. Prior to the transfer, patients were treated with tetracycline 250 mg q4h, but this was discontinued the day after transfer. Patients were placed in a semilithotomy position. A Norfolk transfer cannula consisting of a 20 ga Teflon tubing with side opening was used.[5] Prior to transfer, the syringe (1 cc) and catheter were aseptically flushed, then filled with growth medium wrapped in sterile covering and placed overnight in the CO_2 incubator. At transfer, excess growth medium was expelled; then, 20 to 30 microliter columns of air, growth medium, air, and growth medium were aspirated into the catheter. Embryos were placed in the central GM column via hand-drawn glass micropipet, and the assembled apparatus handed to the transfer physician. The cervix was wiped with a cotton-tipped applicator and a single-toothed tenaculum applied. The Norfolk cannula was inserted into the external os and the Teflon catheter was inserted to a premeasured distance. After gently compressing the syringe plunger to expell the embryo into the womb, the tubing was retracted and the cannula removed. The cannula then was examined (20 to 40 x stereoscope) to ensure that the embryo had been transferred. The patient remained in Trendelenburg position for 4 to 6 hours and then discharged.

Post-transfer patients were seen every three days to check serum estradiol and progesterone levels. At each visit, 1,000 I.U. hCG were administered intramuscularly (unless serum E2 level at the previous visit exceeded 500 pg/ml) starting with the day of transfer. If no menses had occurred 16 days post-transfer, a beta-hCG level (serum) was obtained, and positive results were verified by subsequent presence of an intrauterine gestational sac on sonography.

RESULTS

Twenty-seven women were started on ovulation-inducing medication for 50 treatment cycles. Of these 50, 25 treatment cycles were abandoned because follicular development was deemed unsatisfactory by above criteria. Four of the 27 patients never came to laparoscopy because of inadequate follicular development.

In 23 patients, 25 treatment cycles led to laparoscopy and, in 3 patients, to laparotomy. Oocytes were recovered in 20 situations, with a mean recovery rate of 1.8/case. Fertilization (as per cleavage) was noted in 18 of 20 cases with a rate of 1.7/case. Embryo transfer was performed in 18 patients. Figure 1 demonstrates representative stages of oocyte/embryo development in culture.

In 16 patients, menses occurred approximately 14 days post-transfer. Two patients conceived (Table 2).

TABLE 2

Result of IVF Therapy in 23 Patients Who Underwent 25 Laparoscopies

• Laparoscopies	25
• Oocytes recovered	20 (80%)
• Transfers	18 (72%)
• Pregnancy	2 (8%)

PREGNANCIES

Patient 1 (Figure 3) is a 32-year-old P0020 who had two previous ectopic pregnancies resulting in right salpingectomy and left salpingo-oophorectomy.

After her last menstrual period on October 14, 1983, a clomiphene citrate-hMG regimen was started and

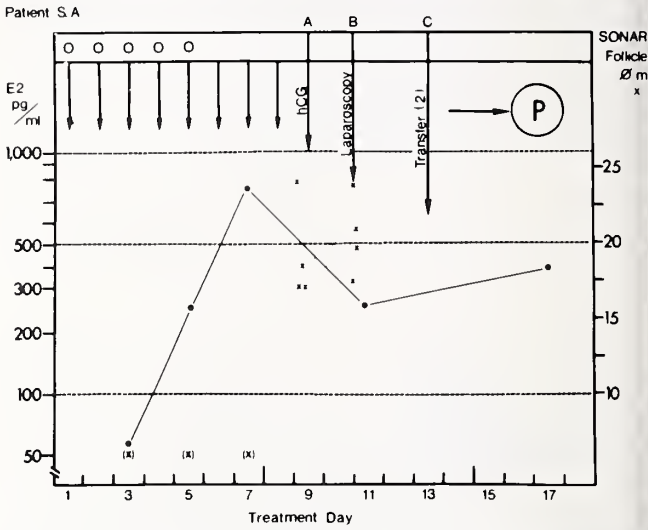


Figure 3—Treatment cycle of first patient who conceived (cles: 50 mg clomiphene citrate; small arrows: 75 I.U. hMC 5,000 I.U. hCG; B: laparoscopy; C: embryo transfer; (P): pr nancy test positive 16 days after transfer).

monitored by serum estradiol and sonography. h was administered on October 24, with laparoscopy hours later; two oocytes were recovered. Both oocy were fertilized and underwent cleavage, and on Oc ber 27 both oocytes were transferred. The pregnar test on November 14 was positive, and a followup so gram verified presence of a single intrauterine ges tion.

Patient 2 is a 30-year-old P0000 with failed bilate fimbrioplasty in 1979. In addition, on Sims-Huh test, spermatozoa were noted to be nonmobile, an test for cervical sperm-antibodies (Elisa) was positi After her last menstrual period on November 5 clomiphene citrate-hMG regimen was initiated a monitored using E2 levels and sonograph Laparoscopy was performed on November 18, 1983 (hours post-hCG), and one oocyte was recovered. Af fertilization and cleavage, the embryo was transfer on November 21. A positive pregnancy test was tained December 6, 1983, verified three weeks later sonography.

COMMENT

This report describes our first experience with vitro fertilization (IVF) in New Jersey. Locally, the ception of the procedure was favorable and met major objections. To minimize concern regardi "extra" fertilized egg cells, our policy is to place fertilized, normally developing oocytes into the n ternal womb. Indeed, the reinsertion of more than o embryo has been shown to increase the probability establishing a pregnancy. No embryo was arbitrar abandoned. Embryos were left undisturbed during c ture except for minimal examination to assess develo

ent. Initial concerns about the outcome of these "un-tural" pregnancies largely have been alleviated by e experience of other IVF programs with an increas- number of seemingly normal pregnancy outcomes. vertheless, further observation and caution appear dent until sufficient experience has been attained assess adequately the long-term implications of in ro fertilization procedure. All patients are made are of this issue.

Patients specifically were quite receptive to the local roduction of IVF; for many patients, travel—perhaps eatedly—to a distant IVF center is psychologically d economically disadvantageous. The central lo- ion of the IVF facilities in New Brunswick makes ossible for some patients to continue their daily tine as they participate in the program.

The main side effect upon participants of the IVF gram is stress. Despite thorough and rational ex- nations, each couple believes that they will be the ky one who "beats the odds." We have found it help- to institute an ongoing counselling program, to vide not only psychological support and education patients, but also to provide feedback to IVF person- so that the programs will be sensitive to patient ds.

Results of our work fall well within those seen in the reported IVF experience.

here are a number of points in which our program ers from the majority of other programs:

The Rutgers Medical School program has been e to enter interested patients relatively quickly into screening process. Although some programs have cribed waiting lists of several hundreds or even usands of patients, it is apparent that many names waiting lists represent inactive or ineligible pa- ts. Seriously interested patients usually can be n within a few months.

In our program, evidence of normal ovulation was a prerequisite for admission. We believe that as ients are treated with ovulation-inducing agents, presence of normal ovulation in unstimulated cy- may be of little relevance. At this time, the patients h elevated FSH levels (indicating ovarian failure) are igible.

It appears to us that most programs either use niphene citrate or human menopausal gonado- in (hMG) regimens to control follicular growth. program uses a combined clomiphene-hMG-hCG men which appears to give us relatively controlled, dictable growth of follicles. Nonetheless, a signifi- t number of induction cycles were terminated prior urgery because of inappropriate follicular response. complications were encountered with this ap- ach.

Whereas many programs use a rapid LH assay to ne the LH surge, we rely on other criteria to evalu- patients just prior to laparoscopy. Our criteria for ceeding with laparoscopy include: 1) a normal estradiol profile; 2) sonographically defined progressive follicular growth; and 3) at least two sonographically defined follicular cysts for harvesting. The rationale of this approach is to obtain germ cells from well-stimulated follicles in adequate number to improve the overall chance of success.

- Many programs use medication to support the luteal phase and, in general, progesterone supplementation appears popular. We are using a supplemental regimen of hCG, on the basis that hCG will stimulate the ovarian corpus luteum and then raise both endogenous estrogen and progesterone, whereas exogenous progesterone supplementation may distort the estrogen/progesterone ratio.

Our results fall well within those seen in the reported IVF experience: the efficacy of IVF in summary of 2,037 laparoscopies done worldwide at 12 centers indicates a transfer rate of 55 percent, and a pregnancy rate of 8 percent; the pregnancy rate was 16.5 transfers/pregnancy.[6] Our results are very similar to this overall experience. Although the future of IVF appears promising, there are a number of issues which require careful attention. Foremost, the efficiency (pregnancies/laparoscopy) of IVF procedures needs to be improved. As a medical procedure, IVF still is in the early developmental stage and it is reasonable to expect significant improvement with cumulative experience. As efficiency increases, IVF may compete more effectively with tubal surgery as a primary approach to overcome tubal infertility. Applications other than tubal problems need to be defined further. As most centers, we have opened access to our program now to those patients who have unexplained infertility, endometriosis with failed previous therapy, and patients whose husbands have untreatable oligospermia. At the same time, however, it should be recognized that patients in these latter categories may have pathophysiologies less amenable to IVF therapy than those with tubal occlusions. We also increased the age limit to allow patients up to 39 years to enter the program.

A major problem for many patients is the current classification of IVF procedures as "experimental" by insurance carriers. The expense of the procedure (about $5,000 per attempt) is composed of labor intensive elements many of which are, by themselves, accepted medical procedure. The current situation makes it difficult for a sizable number of infertile couples for whom IVF offers perhaps the only possibility for achieving pregnancy to take advantage of this procedure's potential.

ADDENDUM

Since the completion of the article both patients who were pregnant have delivered. Patient 1 was delivered at term by cesarean section on July 18, 1984, of a healthy, male infant weighing 10 pounds, 1 ounce. The indication was cephalopelvic disproportion with a large infant who never entered the pelvis. The prior pregnancy course had been uneventful.

Patient 2 delivered at 37½ weeks a healthy 6 pound, 5 ounce male infant on July 23, 1984. This delivery also was by cesarean section with an indication of placenta previa. During this pregnancy, several episodes of pain-

less vaginal bleeding had occurred since July 3, and required hospitalization on two occasions. Sonogram studies indicated placenta previa as cause. Delivery occurred electively after maturity studies had been performed, and the operation confirmed the presence of a placenta previa.

Both mothers and infants are doing well.

REFERENCES

1. Steptoe PC, Edwards RG: Birth after the reimplantation of a human embryo. *Lancet* 2:366, 1978.
2. Jones HW Jr, Jones GS, Andrews HC, Acosta A, Bundren C, Garcia J, Sandow B, Veeck L, Wilkes C, Witmyer J, Worth JE, Wright G: The program for in vitro fertilization at Norf *Fert Steril* 38:14-21, 1982.
3. Garcia J, Acosta A, Andrews MC, Jones GS, Jones Jr, Mantzaviros T, Mayer F, McDowell J, Sandow B, Veecl Whibly T, Wilkes C, Wright G Jr: In vitro fertilization in N folk, Virginia, 1980-1983. *J In Vitro Fert Embryo Tra* 1:24-28, 1984.
4. Acosta A: Proceedings of the in vitro fertilization wo shop, Norfolk, VA, Sept 1982. *Infertility*, 6:1-4, 1983.
5. Jones HW Jr, Acosta A, Garcia J, Sandow B, Veeck L: the transfer of conceptuses from oocyte fertilized in vitro. *F Steril* 39:241-243, 1983.
6. Grobstein C, Flower M, Mendeloff J: *Scie* 222:127-133, 1983.

Motrin reduces inflammation, pain ...and price

New low price...major savings

The dramatic reduction in the price of *Motrin* Tablets means substantial savings from now on for your patients and for patients all across the country for whom *Motrin* Tablets are prescribed.

Motrin is priced lower than Clinoril, Feldene, or Naprosyn.

The price of *Motrin* Tablets to pharmacies has been reduced as much as 35%. Patients taking the average dosage should now pay less for therapy with *Motrin* Tablets than for almost any other nonsteroidal anti-inflammatory drug you prescribe...less, for example, than for Clinoril, Feldene, or Naprosyn. And, of course, all strengths of *Motrin* Tablets continue to be available by prescription only.

Please see the following page for a brief summary of prescribing information.

Motrin® 400 & 600 mg TABLETS
ibuprofen

Good medicine...good value

© 1984 The Upjohn Company

The Upjohn Company **Upjohn** Kalamazoo, Michigan 49001

Motrin® Tablets (ibuprofen)

Contraindications: Anaphylactoid reactions have occurred in individuals hypersensitive to *Motrin* Tablets or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin, iodides, or other nonsteroidal anti-inflammatory agents.

Warnings: Peptic ulceration and GI bleeding, sometimes severe, have been reported. Ulceration, perforation and bleeding may end fatally. An association has not been established. Use *Motrin* Tablets under close supervision in patients with a history of upper gastrointestinal tract disease, after consulting ADVERSE REACTIONS. In patients with active peptic ulcer and active rheumatoid arthritis, try nonulcerogenic drugs, such as gold. If *Motrin* Tablets are used, observe the patient closely for signs of ulcer perforation or GI bleeding.

Chronic studies in rats and monkeys have shown mild renal toxicity with papillary edema and necrosis. Renal papillary necrosis has rarely been shown in humans treated with *Motrin* Tablets.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue *Motrin* Tablets and the patient should have an ophthalmologic examination, including central visual fields and color vision testing.

Fluid retention and edema have been associated with *Motrin* Tablets; use with caution in patients with a history of cardiac decompensation or hypertension. In patients with renal impairment, reduced dosage may be necessary. Prospective studies of *Motrin* Tablets safety in patients with chronic renal failure have not been done.

Motrin Tablets can inhibit **platelet aggregation** and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and on anticoagulant therapy.

Patients should report signs or symptoms of **gastrointestinal ulceration** or bleeding, skin rash, weight gain, or edema.

Patients on prolonged **corticosteroid therapy** should have therapy tapered slowly when *Motrin* Tablets are added.

The antipyretic, anti-inflammatory activity of *Motrin* Tablets may mask inflammation and fever.

As with other nonsteroidal anti-inflammatory drugs, borderline elevations of liver tests may occur in up to 15% of patients. These abnormalities may progress, may remain essentially unchanged, or may be transient with continued therapy. Meaningful elevations of SGPT or SGOT (AST) occurred in controlled clinical trials in less than 1% of patients. Severe hepatic reactions, including jaundice and cases of fatal hepatitis, have been reported with ibuprofen as with other nonsteroidal anti-inflammatory drugs. If liver disease develops or if systemic manifestations occur (e.g. eosinophilia, rash, etc.), *Motrin* should be discontinued.

Drug interactions. *Aspirin:* used concomitantly may decrease *Motrin* blood levels.

Coumarin: bleeding has been reported in patients taking *Motrin* and coumarin.

Pregnancy and nursing mothers: *Motrin* should not be taken during pregnancy or by nursing mothers.

Adverse Reactions: The most frequent type of adverse reaction occurring with *Motrin* is gastrointestinal of which one or more occurred in 4% to 16% of the patients.

Incidence Greater than 1% (but less than 3%)—Probable Causal Relationship

Gastrointestinal: Nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence); **Central Nervous System:** Dizziness,* headache, nervousness; **Dermatologic:** Rash* (including maculopapular type), pruritus; **Special Senses:** Tinnitus; **Metabolic/Endocrine:** Decreased appetite; **Cardiovascular:** Edema, fluid retention (generally responds promptly to drug discontinuation; see PRECAUTIONS).

Incidence less than 1%—Probable Causal Relationship**

Gastrointestinal: Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, melena, gastritis, hepatitis, jaundice, abnormal liver function tests; **Central Nervous System:** Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma; **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia; **Special Senses:** Hearing loss, amblyopia (blurred and/or diminished vision, scotomata, and/or changes in color vision) (see PRECAUTIONS); **Hematologic:** Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit; **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations; **Allergic:** Syndrome of abdominal pain, fever, chills, nausea and vomiting; anaphylaxis; bronchospasm (see CONTRAINDICATIONS); **Renal:** Acute renal failure in patients with pre-existing significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria; **Miscellaneous:** Dry eyes and mouth, gingival ulcer, rhinitis.

Incidence less than 1%—Causal Relationship Unknown**

Gastrointestinal: Pancreatitis; **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri; **Dermatologic:** Toxic epidermal necrolysis, photoallergic skin reactions; **Special Senses:** Conjunctivitis, diplopia, optic neuritis; **Hematologic:** Bleeding episodes (e.g., epistaxis, menorrhagia); **Metabolic/Endocrine:** Gynecomastia, hypoglycemic reaction; **Cardiovascular:** Arrhythmias (sinus tachycardia, sinus bradycardia); **Allergic:** Serum sickness, lupus erythematosus syndrome, Henoch-Schonlein vasculitis; **Renal:** Renal papillary necrosis.

*Reactions occurring in 3% to 9% of patients treated with *Motrin*. (Those reactions occurring in less than 3% of the patients are unmarked.)

**Reactions are classified under *"Probable Causal Relationship (PCR)"* if there has been one positive rechallenge or if three or more cases occur which might be causally related. Reactions are classified under *"Causal Relationship Unknown"* if seven or more events have been reported but the criteria for PCR have not been met.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine so alkaline diuresis may be beneficial.

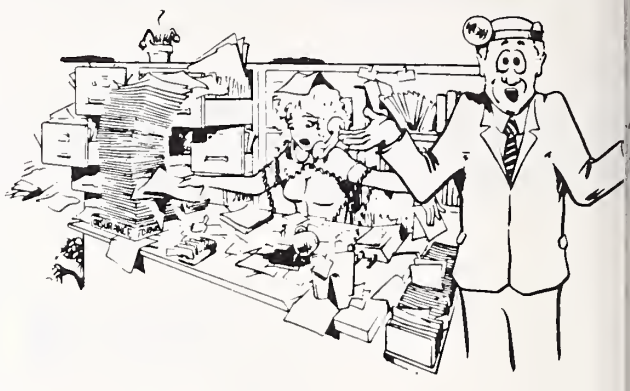
Dosage and Administration: Rheumatoid arthritis and osteoarthritis. Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Do not exceed 2400 mg per day. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary.

Caution: Federal law prohibits dispensing without prescription. MED B-7-S

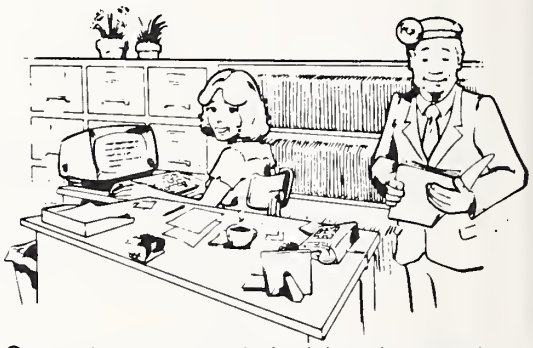
Motrin is a registered trademark of The Upjohn Manufacturing Company

Upjohn The Upjohn Company
Kalamazoo, Michigan 49001

My Patients Were Fine... My Practice Was Ailing!



My Remedy: EXECU-FLOW SYSTEMS... "A Good Shot In The Arm!"



Computers are revolutionizing the practice of medicine. Execu-Flow Systems is at the forefront of this revolution, providing you with the latest in software/hardware technology.

You can start with Patient Billing and Insurance Processing, and add other systems such as Appointment Scheduling, Medical Records, Electronic Claims, Word Processing, etc.

Our many years of experience with practices such as yours, **GUARANTEES** our mutual success. Our system provides you with the peace-of-mind in knowing that your practice is operating at peak efficiency.

Could *your practice* use a *"Shot in the Arm?"*

- **Multi-tasking** IBM XT/IBM 9000/ CONTEL CADO Systems
- Software for *YOUR SPECIALTY*
- Automatic Prescription System
- Complete "Paperless" Office Available
- Comprehensive Patient Recall System

EXECU-FLOW SYSTEMS INC

2013 Morris Avenue, Union, N.J. 07083
or call (201) 851-0750

Myth or Fact: Can Women Self-Diagnose Pregnancy?

Gloria A. Bachmann, M.D., New Brunswick*

The unproved belief that most women can self-diagnose pregnancy before medical confirmation is accepted widely. To test the accuracy of self-diagnosis, 283 women who requested a pregnancy test because of late menses were asked to complete a structured, self-administered questionnaire.

The diagnosis of pregnancy is based on symptoms and signs, especially missed menses, elicited by history taking, physical examination, and laboratory procedures. Most often the diagnosis rests with detection of human chorionic gonadotropin (HCG) in urine or serum.[1] Although some current pregnancy tests can detect HCG nine days after ovulation, in general most detect HCG after the first missed menses. However, false negative and false positive results can occur because of substances interfering with the HCG measurement or by HCG or HCG-like secretion in the absence of pregnancy.[2] Moreover, HCG detection in the urine is a probable sign of pregnancy rather than an absolute sign. Identification of fetal heart activity, perception of fetal movement by the examiner, and the recognition of the fetus radiologically or sonographically are considered absolute signs of pregnancy.

Some physicians believe that the diagnosis of pregnancy can be supported before absolute signs are recognizable by asking the woman if she is pregnant.[3] Self-prediction of pregnancy is of special interest in the area of in vitro fertilization.

Can women accurately predict those cycles in which the implanted fertilized ovum has resulted in a pregnancy? This research studied the accuracy of a woman's self-prediction of pregnancy before pregnancy test results and physical examination were known to her. It also evaluated specific factors affecting her diagnosis.

MATERIALS AND METHODS

Two hundred eighty-three women, aged 16 through 28 years (mean, 22.8 years), who requested a pregnancy test because of a late menses, were studied at three health centers in New Brunswick. Six women (2 percent) of the sample wanted to be pregnant. Sixty-four (23 percent) women had previous pregnancy experience. Ninety-eight percent of the sample had their last menses 60 days or less before requesting a pregnancy test. Each woman was asked to fill out a comprehensive, structured contraception and sexual history questionnaire which included questions on whether she believed she was pregnant, and if subjective symptoms of pregnancy were present. All questionnaires were filled out before the results of the pregnancy test (NeoCept®) were available and before a physical examination was done.

NeoCept® is a urine test for pregnancy based on the hemagglutination inhibition reaction between HCG-sensitized blood cells and antisera to HCG. It is positive

*Dr. Bachmann is affiliated with the Department of Obstetrics and Gynecology, UMDNJ-Rutgers Medical School. Correspondence may be addressed to Dr. Bachmann, UMDNJ-Rutgers Medical School, Department of Obstetrics and Gynecology, Academic Health Science Center, CN 19, New Brunswick, NJ 08903.

at an average of 16 days after ovulation, at which time the concentration of HCG in the urine is about 200 mIU/ml.[4] This corresponds to about the time of the first missed period.

RESULTS

Of the 283 pregnancy tests, 118 (42 percent) were positive and 165 (58 percent) were negative. Of 118 women with positive pregnancy tests, 92 percent were correct in stating they were pregnant; women with previous pregnancy experience were 94 percent accurate. Of 105 women with negative pregnancy tests, 57 percent incorrectly stated they were pregnant; 64 percent with previous pregnancy experience incorrectly thought they were pregnant.

Accuracy of Prediction. Of the 283 women requesting pregnancy tests, 204 thought they were pregnant, however, only 109 (53 percent) did have a positive pregnancy test. Of the 79 subjects who did not think they were pregnant, 70 (89 percent) were correct and had negative pregnancy tests while 9 (11 percent) were inaccurate and indeed were pregnant (Figure). Of the study population, 64 women who had previous pregnancy experience were not more accurate in their prediction of pregnancy than the rest of the group.

Subjective Symptoms and Signs of Pregnancy. Of the 118 subjects with positive pregnancy tests, 59 (50 percent) felt pregnant as compared to 34 (21 percent) of the 165 women with negative pregnancy tests.

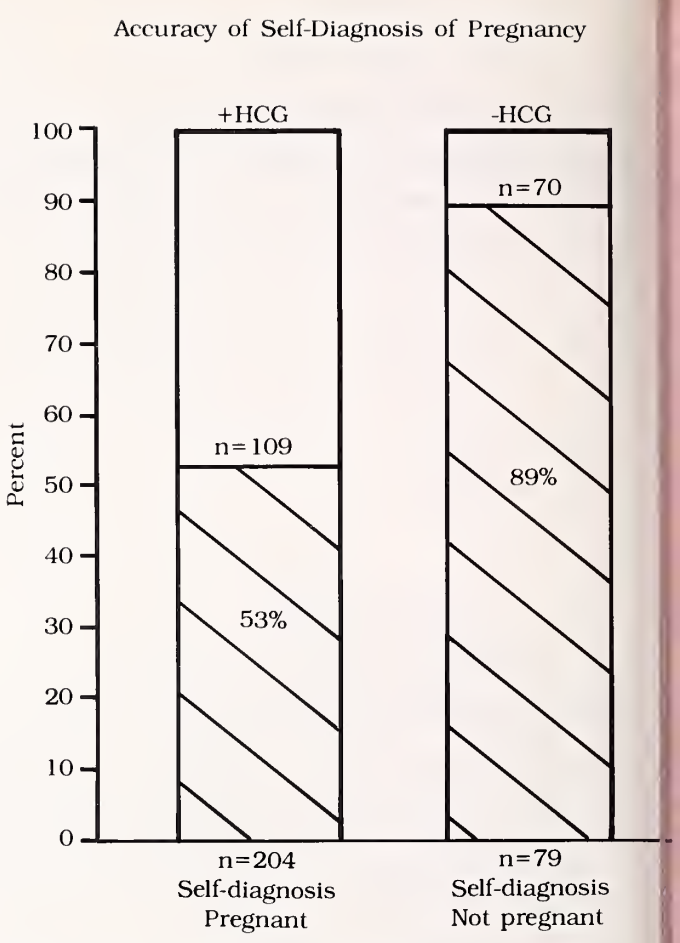
Accuracy of Pregnancy Prediction of Subjective Symptoms. Eighty-nine (44 percent) of the 204 women who thought they were pregnant had subjective symptoms of pregnancy. Of these 89 women, 57 subsequently had a positive HCG. Therefore, of all women who thought they were pregnant, only 57 (29 percent) had symptoms of pregnancy and indeed were pregnant; 32 women (15 percent) had symptoms but were not pregnant.

Of the 79 women who did not think they were pregnant, only 5 percent had symptoms of pregnancy. Of this group, only 2 (3 percent) with a subsequently negative test reported subjective symptoms.

Unprotected Intercourse and Contraceptive Use. Women who felt they were pregnant reported the higher percentage of unprotected intercourse (59 percent as compared to 36 percent). As expected, women who thought they were pregnant and subsequently had a positive pregnancy test had the higher rate of unprotected intercourse (71 percent), and the higher percentage of failure to use contraceptive agents (16 percent compared to 10 percent).

DISCUSSION OF RESULTS

Women who requested a pregnancy test to rule out an unwanted pregnancy did not have a high degree of accuracy in predicting pregnancy. Only 53 percent were correct in accurately self-diagnosing pregnancy. However, of those women not believing they were pregnant, 89 percent were accurate. Symptoms of pregnancy were reported more often by women with positive pregnancy tests who thought they were pregnant, but subjective symptoms were not more accurate than the woman's self-prediction of pregnancy. The



Figure—Accuracy of the self-diagnosis of pregnancy.

women who did not have symptoms of pregnancy w more accurate in the prediction that they were n pregnant. As expected, women who thought they w pregnant were less consistent in contraceptive tec niques as compared to those who did not think th were pregnant. In fact, more women requested a pr nancy test because of unprotected intercourse th because of pregnancy symptoms. Despite recent a vances in fertility control techniques, many wom especially in this younger population avoid or are i consistent with contraception.

SUMMARY

It appears that self-diagnosis is not accurate in pr dicting pregnancy and physicians should not rely history alone. Many women assume that they are pre nant after a missed menstrual period until pregnan testing and pelvic examination give them a conclusi answer. However, if a woman states she is not pre nant, she most probably is correct. Data from a pop lation of women desirous of pregnancy and from population of women undergoing in vitro fertilizati are needed for comparison.

REFERENCES

1. Williams: *Obstetrics, 12th Edition.* 1980, p. 261.
2. Horwitz CA: Pregnancy tests 1980: Advantages and lir tations. *Lab Med* 11:620, 1980.
3. Derman R, Corson S, Horwitz CA, Lau HL, Soderstr R: Early diagnosis of pregnancy: A symposium. *J Repro M* 26:4, 1981.
4. Wang CF, Gemzell C: Neocept®: A simple, sensitive uri test of early pregnancy in women undergoing ovulation duction. *J Repro Med* 4:193-195, 1982.

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android®/5 mg. Buccal/10 mg. Oral/25 mg. Oral
Methyltestosterone U.S.P. Tablets

ANDROID®/F
Fluoxymesterone U.S.P. Tablets, 10 mg.





Just once each day...

First-step blood pressure control with optimal simplicity

Benefits diuretics cannot offer... Once-daily INDERAL LA (propranolol hydrochloride) with its smooth 24-hour control of blood pressure provides a high degree of patient acceptance without potassium problems, plus the cardiovascular benefits of the world's leading beta blocker.

Experience no other beta blocker can match... Once-daily INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.



Start with 80 mg once daily... Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



80 mg 120 mg 160 mg

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories

Ayerst

Just once each day for initial therapy in hypertension.

Just once each day for initial therapy in HYPERTENSION.

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



80 mg 120 mg 160 mg

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking prior to major surgery is controversial. It should be noted, however, that the impaired the heart to respond to reflex adrenergic stimuli may augment the risks of general an and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor receptor agonists and its effects can be reversed by administration of such agen dobutamine or isoproterenol. However, such patients may be subject to protracte hypotension. Difficulty in starting and maintaining the heartbeat has also been repo beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may preven pearance of certain premonitory signs and symptoms (pulse rate and pressure cha acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperth Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of s of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid funct

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases ha reported in which, after propranolol, the tachycardia was replaced by a severe bra requiring a demand pacemaker. In one case this resulted after an initial dose propranolol.

PRECAUTIONS. *General.* Propranolol should be used with caution in patients with hepatic or renal function. INDERAL is not indicated for the treatment of hype emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure should be told that INDERAL may interfere with the glaucoma screening test. Withdr lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such pine should be closely observed if INDERAL is administered. The added catech blocking action may produce an excessive reduction of resting sympathetic nervou which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or o hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in anim been conducted to evaluate toxic effects and carcinogenic potential. In 18-month s both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of s drug-induced toxicity. There were no drug-related tumorigenic effects at any of the levels. Reproductive studies in animals did not show any impairment of fertility attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embry animal studies at doses about 10 times greater than the maximum recommended hum

There are no adequate and well-controlled studies in pregnant women. INDERA be used during pregnancy only if the potential benefit justifies the potential risk to t

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercis INDERAL is administered to a nursing woman.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient a rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV bloc tension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usua Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by i lassitude, weakness, fatigue; reversible mental depression progressing to cataton disturbances; hallucinations; an acute reversible syndrome characterized by disorier time and place, short-term memory loss, emotional lability, slightly clouded sensor decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined wi and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thromboc purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus h reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, ma tence, and Peyronie's disease have been reported rarely. Oculomucocutaneous involving the skin, serous membranes and conjunctivae reported for a beta blocker (p have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochl sustained-release capsule for administration once daily. If patients are switched from tablets to INDERAL LA capsules, care should be taken to assure that the desired the effect is maintained. INDERAL LA should not be considered a simple mg for mg sub INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitra be necessary especially to maintain effectiveness at the end of the 24-hour dosing

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage INDERAL LA once daily, whether used alone or added to a diuretic. The dosage increased to 120 mg once daily or higher until adequate blood-pressure control is a The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosa mg may be required. The time needed for full hypertensive response to a given c variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg IND once daily, dosage should be gradually increased at three to seven day intervals until response is obtained. Although individual patients may respond at any dosage average optimum dosage appears to be 160 mg once daily. In angina pectoris, the v safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a fe (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg IND once daily. The usual effective dose range is 160-240 mg once daily. The dosage increased gradually to achieve optimum migraine prophylaxis. If a satisfactory respo obtained within four to six weeks after reaching the maximum dose, INDERAL LA should be discontinued. It may be advisable to withdraw the drug gradually over a several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age grou limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Lab

89-1/2

Ayerst® AYERST LABORATORIES
New York, N.Y. 10017

Risks Associated With Post-traumatic Flashbacks*

Allan Burstein, M.D., Freehold*

Post-traumatic flashbacks occur in 8 to 13 percent of persons following a war experience, catastrophe, motor vehicle or industrial accident, or assault. Sixty patients were evaluated and 13 were found to have post-traumatic flashbacks. Physicians should anticipate problems and look for and treat flashbacks.

Post-traumatic flashbacks are clearly perceived revisualizations of the trauma scene or a auma-related scene occurring with realistic intensi- The traumatic experience may be a war experience, catastrophe, or much more prevalent traumas such motor vehicle accidents, industrial accidents, or assaults. An incidence for flashbacks of 8 to 13 percent as been noted in bereaved widows,[1] combat veterans,[2] d a mixed trauma group.[3]

The dangers associated with hallucinations, as cur in schizophrenia or delirium, are well-recgnized.[4] In response to an imagined threat, the individual may exhibit a flight reaction and, for example, ap from an open window. It is believed that such ght reactions are possible with post-traumatic shbacks, but very few references to this problem pear in the literature. Furthermore, such possibiles are not necessarily recognized by the physician eating the victims of motor vehicle accidents, assaults, or other commonly seen traumas.

ETHOD AND RESULTS

The following study was undertaken to ascertain the evalence of dangerous flashbacks commonly enountered among medical-surgical patients referred r psychiatric consultation.

Sixty patients who met the DSM III criteria for postaumatic stress disorder (Table) were evaluated as they were referred from medical specialists for consultation in the hospital or office. The evaluation consisted of an interview and confirmation of symptoms from a family member or from a treating professional.

Twenty (33 percent) of this group reported flashbacks (10 males and 10 females; mean age 32.3). Care was taken to distinguish between revisualizations and other visual imagery, i.e. illusions. Confirmation was obtained in 13 cases. The traumatic stresses involved were: motor vehicle accidents (n=11); assaults (n=4); work-related accidents (n=3); and other (n=2). The mean time from the trauma to the evaluation was 32.7 weeks. Of these 20 patients, none had a prior history of psychiatric problems or manifestations of psychotic symptoms, or alcohol or drug abuse.

In all cases, the revisualizations, which consisted of a scene from the trauma lasting for a minute or less, were precipitated by an event reminiscent of the trauma (a thought, a pain, or a similar situation). The flashbacks occurred either frequently (several times/week, n=16) or rarely (2 or fewer episodes, n=4).

In nine of these cases (45 percent) the flashbacks precipitated either a dangerous or a potentially dangerous situation, according to the judgment of the patients, witnesses, and this investigator. The trau-

*Dr. Burstein is in private practice. Correspondence may be addressed to Dr. Burstein, Wemrock Professional Mall, 505 Stillwells Corner Road, Freehold, NJ 07728.

matic events in these cases were either a motor vehicle accident (n=8) or an industrial accident (n=1). In this group, confirmation was obtained in seven cases.

CASE REPORT 1

A 35-year-old petrochemical worker was involved in a plant explosion. Severe burns resulted in a lengthy hospitalization. During that time he began to experience frightening dream disturbances in which scenes of the accident were repeated. He became depressed and, once home, quarreled often with his wife. There was no sexual interest nor interest in any of his prior activities. At times he would start to cry for no apparent reason. Seven months after the accident he returned to work, but several weeks later there was another explosion. Standard procedure at the plant would have been an immediate response on his part to help his coworkers and stop the fire. However, he froze at the sight of the flames and revisualized his prior accident. Subsequently, he felt guilty and quite vulnerable. He requested and was granted a change in work status.

CASE REPORT 2

A 22-year-old woman was involved in a motor vehicle accident which resulted in facial lacerations and orthopedic injuries. Following the accident, she began to have dream disturbances involving a repetition of the accident. The dreams were so vivid that sleep which already was disturbed became impossible. She was depressed, withdrew from social relationships, and discontinued her modeling career. When she resumed driving she found herself experiencing frequent (several per week) flashbacks of the accident. At times, she would "freeze" behind the wheel, scream, or "slam on the brakes." She attempted to cope with the flashbacks by either not driving or driving as slowly as possible.

DISCUSSION

This study suggests that flashbacks occurring during tasks that involve concentration and quick judgment pose a risk to the patient and others. Moreover, they are not rare in general medical practice. This evaluation only dealt with patients who were referred for psychiatric consultation. Many medical and surgical practitioners, however, treat their patients' psychiatric disorders without psychiatric consultation.[5] Hence, this study reflects only a glimpse of the total picture.

Two reasons for the poor recognition of flashbacks in general practice are suggested. Firstly, a clear, consistent post-traumatic symptom picture has been recognized only within the past few years. Post-traumatic stress disorder formerly was called gross stress reaction, traumatic neurosis, shell shock, or combat fatigue by different investigators. The presentation may be complicated and confusing to the primary physician.

Secondly, as Horowitz has suggested, patients often will not report flashbacks unless specifically asked[6] seeing them as symptoms of "madness" or loss of control.

At this point, treatment considerations are tentative. One pilot study indicates that those individuals experiencing post-traumatic dream disturbances are at risk to experience flashbacks.[7] Case reports sugge that phenelzine[8] and imipramine[9] may stop flashbac as well as calm the patient and control the sleep a dream disturbances. However, more formal study the problem of post-traumatic flashbacks must done.

TABLE

*Diagnostic Criteria for Post-traumatic Stress Disorder**

A. Existence of a recognizable stressor that would evok significant symptoms of distress in almost everyone
B. Re-experiencing of the trauma as evidenced by a least one of the following:
   (1) Recurrent and intrusive recollections of th event
   (2) Recurrent dreams of the event
   (3) Sudden acting or feeling as if the traumati event were reoccurring, because of an associa tion with an environmental or ideational stimu lus
C. Numbing of responsiveness to or reduced involve ment with the external world, beginning some tim after the trauma, as shown by at least one of th following:
   (1) Markedly diminished interest in one or more sig nificant activities
   (2) Feeling of detachment or estrangement fron others
   (3) Constricted affect
D. At least two of the following symptoms that were nc present before the trauma:
   (1) Hyperalertness or exaggerated startle response
   (2) Sleep disturbance
   (3) Guilt about surviving when others have not, o about behavior required for survival
   (4) Memory impairment or trouble concentrating
   (5) Avoidance of activities that arouse recollection c the traumatic event
   (6) Intensification of symptoms by exposure t events that symbolize or resemble the traumati event

*From the *Diagnostic and Statistical Manual of Mentc Disorders. 3rd Edition.* American Psychiatric Associatio

REFERENCES

1. Parkes CM: The first year of bereavement; A longitudi study of reaction of London widows to the death of th husbands. *Psychiatry* 33:444-467, 1970.
2. Panzarella RF, Mantell DM, Bridenbargh RH: Psychiat syndromes, self concepts, and Vietnam veterans, in Figley ((ed), *Stress Disorders Among Vietnam Veterans.* New Yo NY, Bruner Mazel, 1978, p. 161.
3. Horowitz MJ, Wilner H, Kaltreider N, et al.: Signs a symptoms of post-traumatic stress disorder. *Arch Gen P chiatry* 37: 85-92, 1980.
4. Linn L: Clinical manifestations of psychiatric disorde in Kaplan HI, Freedman AM, Sadock BJ (eds), *Co prehensive Textbook of Psychiatry/III.* Baltimore, MD, V liams and Wilkins, 1980, p. 1018.
5. Fauman MA: Psychiatric components of medical a surgical practice, II: Referral and treatment of psychiat disorders. *Am J Psychiatry* 140: 760-763, 1983.
6. Horowitz MJ: *Stress Response Syndromes.* New Yo NY, Jason Aronson Inc., 1976, p. 37.
7. Burstein A: Dream disturbances and flashbacks. *J C Psychiatry* (in press).
8. Hogben GL, Cornfield RB: The treatment of trauma war neurosis with phenelzine. *Arch Gen Psychia* 38:440-445, 1981.
9. Burstein A: Imipramine treatment of flashbacks. *An Psychiatry* 140:509, 1983.

JEMPAC New Jersey Medical Political Action Committee

VOTE.

EXERCISE YOUR RIGHT.

NOVEMBER 6, 1984

A Public Service of JEMPAC

Copies of JEMPAC and AMPAC reports are filed with the Federal Election Commission and are available for purchase from The Federal Election Commission, Washington, D.C.

It's Your Affair, So Don't Lift A Finger

Since we want your special day to be carefree just lift the phone and call

Parties Unlimited

Perfect Catering For A Perfect Affair

Trenton, New Jersey
609-890-0778

TAX SHELTERS

Just one of the personal financial services available to you from the ***physician's bank.***

- tax planning
- lines of credit
- equipment financing
- retirement planning

- money management
- cash flow • investments
- estate planning

Call or Write
Joseph J. Verbaro, Jr.
Senior Vice President
(201) 228-9770

FINTRUST
FINANCIAL AND TRUST SERVICES
DIVISION OF SECURITY NATIONAL BANK & TRUST COMPANY OF NEW JERSEY
101 Eisenhower Parkway
Roseland, New Jersey 07068 Member F.D.I.C

Doctors: Write your own prescription to cure insurance pains . . .

℞ Prescription

Name MSNJ Member

MSNJ Group
Blue Cross/Blue Shield Major Medical and Dental Insurance

that provides:

- **Flexible plans**
- **Comprehensive benefits**
- **Low, competitive rates**
- **Centralized Administration**

Designed and Administered by
DONALD F. SMITH & ASSOCIATES

℞ Prescription

Name _____

Address _____

Phone _____

Please send more information on the MSNJ

- ☐ Blue Cross/Blue Shield Program
- ☐ Major Medical Program
- ☐ Group Dental Program

Return to:
Donald F. Smith & Associates
One Airport Place, Route 206 North
P.O. Box 2197,
Princeton, New Jersey 08540
(609) 924-8700, (201) 622-6046

Midtrimester Amniocentesis for Prenatal Diagnosis

Abraham Ghiatas, M.D., Long Branch*

At Monmouth Medical Center, 152 women underwent amniocentesis because of advanced maternal age, suspected neural tube defect, or adverse family history for chromosomal or biochemical disorders. Amniocentesis in the midtrimester of pregnancy is a safe and accurate method of prenatal diagnosis.

The improvement of cytogenetic and tissue culture techniques as well as the widespread acceptance of amniocentesis as a diagnostic aid, have allowed the detection of many inborn errors of metabolism and chromosome abnormalities, such as trisomy 21 and Tay-Sachs disease.

In 1955, investigators were using the presence of x-chromatin in the nuclei of amniotic fluid cells for prenatal sex determination.[4] In 1965, adrenogenital syndrome was diagnosed in a fetus by measuring the levels of 17 ketosteroids and pregnanetnol in amniotic fluid obtained in the 39th week of gestation.[4] In 1966, the technique of amniotic fluid cell culture was introduced.[4]

INDICATIONS

Amniocentesis is indicated when the risk of an abnormal child is greater than the risk of fetal abnormalities in the general population: advanced maternal age (over 35 years), previous birth of a child with Down's syndrome or any other trisomy, or previous birth of a child with a neural tube defect such as meningomyelocele.[2,3,6] Also, it is indicated when the family history suggests that one parent has or may be a carrier of a disorder that has a chromosomal or biochemical etiology.[3,6]

The results from the work performed at Monmouth Medical Center are shown in Tables 1, 2, and 3.

TECHNIQUE

The procedure is simple. After the abdomen is prepared aseptically, 1 percent lidocaine is used as a local anesthetic. A 22-gauge spinal needle with stylet is used to obtain approximately 30 ml of amniotic fluid. To avoid contaminating the sample with maternal tissue, the stylet must be in place when the needle is advanced. One syringe is used to draw the initial 0.5 ml of fluid to be sure it is clear of blood and then a second syringe is used to obtain the specimen.[5]

Ultrasonography is used prior to amniocentesis to localize placenta, fetus, and fetal age. Also, ultrasonography provides information of the optimal site and depth for insertion of the needle to obtain a sample of amniotic fluid. This is marked on the abdominal wall and amniocentesis is carried out immediately thereafter to minimize changes related to movement of the fetus.

The preferred gestational age for amniocentesis is between 15 to 20 weeks which allows sufficient time to repeat amniocentesis if cell culture fails and also allows a diagnosis before quickening.

After amniocentesis is completed, the fetal heart activity is observed by using ultrasonography.

*Dr. Ghiatas is a resident in diagnostic radiology at Monmouth Medical Center, Long Branch. Correspondence may be addressed to Dr. Ghiatas, Monmouth Medical Center, Third and Pavilion Avenues, Long Branch, NJ 07740.

TABLE 1

Indications for Amniocentesis

Indications	No.	%
Advanced maternal age (included also borderline advanced maternal age)	141	92.7
Neural tube defect	8	5.3
Other	3	2.0

TABLE 2

Gestational Age

Gestational Age	No.	%
Under 15 weeks	2	1.3
15 to 20 weeks	149	98.1
Over 20 weeks	1	0.6

RESULTS AND DISCUSSION

Amniocentesis, a joint procedure at Monmouth Medical Center performed by the Department of Obstetrics and Gynecology and the Department of Radiology, was performed on 152 women over a period of two years (1981 to 1983). Of this group, 120 (78.9 percent) were between 35 to 39 years of age, 12 (7.9 percent) were over 40 years of age, and 20 (13.2 percent) were below the age of 35 (in this group also was included the borderline advanced maternal age, women age 34 to 35). The indications for amniocentesis are summarized in Table 1.

In the group, "other," were two women aged 33 and 28 who underwent amniocentesis due to maternal anxiety and one woman who had multiple radiologic examinations during childhood (age 24).

The reasons given for neural tube defect were: previous delivery of anencephalic child; previous delivery of hydrocephalic and spina bifida child; previous delivery of Down's syndrome child; and family history of Down's syndrome.

Analysis of Table 1 indicates that 98 percent of the performed amniocenteses were indicated and only 2 percent of them were not justified.

The gestational age at the time of amniocentesis is shown in Table 2. Table 2 indicates 98.1 percent of the amniocenteses were performed at the indicated gestational age (15 to 20 weeks) and only 1.9 percent were performed either earlier or later than the indicated gestational age.

The number of attempts to obtain amniotic fluid as well as the gestational week when the attempt was done are shown in Table 3.

Analysis of Table 3 shows that in 89.4 percent of the amniocenteses, amniotic fluid was obtained at the fir attempt and 5.3 percent at the second attempt. Th reason for repeated amniocentesis was failure to o tain fluid on the first or second tap. The reason for d tap was the patient's refusal to allow second tap aft the failure of the first.

COMPLICATIONS

The complications of amniocentesis[1,5,6] can divided into two groups. The first is fetal complic tions: direct fetal trauma; cord hematoma; hemorrha and preterm labor; and premature rupture of the mer branes.

The second group is maternal complications: a nionitis; fetomaternal transfusion; amniotic fluid e bolism; and Rh—isoimmunization.

Only one patient had a complication related to a niocentesis. After the amniocentesis, she abort spontaneously. Communication with the majority the patients, the attending physicians, and the gene counseling office at Monmouth Medical Center did n reveal any other complications.

All of the obtained amniotic fluids were clear exce 11 (7.1 percent) amniocenteses where the amnio fluid was slightly bloody but did not interfere with t cell culture. Only one cell culture indicated trisomy and the patient elected abortion.

SUMMARY

The collected and analyzed data of 152 a niocenteses performed at Monmouth Medical Cent indicate the high degree of safety of the method (or 1 complication in 152 cases) when the procedure performed on justified cases (98 percent in our stud at the indicated gestational age (98.1 percent in o group). Also, it indicated the high degree of success performing the procedure in order to obtain amnio fluid. In our group only 3.3 percent the tap was dry a only 7.1 percent of the obtained amniotic fluid w slightly bloody.

REFERENCES

1. Broome DL, Wilson MG, Weiss B, et al.: Needle punctu of fetus: A complication of second-trimester amniocentes *Am J Obstet Gynecol* 126:247, 1976.

2. Cambell Stuart MB: Early prenatal diagnosis of neu tube defects by ultrasound. *Clin Obstet Gynecol* 20:351-3 1977.

3. Chandra P, Nitowsky HM, Marion R, et al.: Experien with sonography as an adjunct to amniocentesis for prena diagnosis of fetal genetic disorders. *Am J Obstet Gyne* 133:519, 1979.

4. Danford ND: *Obstetrics and Gynecology, 4th Editi* New York, NY, Harper and Row, 1982.

5. Golbus SM: *Ultrasonography in Obstetrics a Gynecology.* Philadelphia, PA, W.B. Saunders, 1983.

6. NICHD National Registry for Amniocentesis Stu Group: Midtrimester amniocentesis for prenatal diagnos safety and accuracy. *JAMA* 236:1471, 1976.

TABLE 3

Amniocentesis Attempts

Attempts	No.	%	Gestational Week						
			15	16	17	18	19	20	20+
1st	136	89.4	4	6	65	41	18	1	1
2nd	9	5.3		2	4	3			
3rd	2	1.4		1		1			
Dry	5	3.3	2		4	1			

TAX SHELTER

Real Estate Limited Partnership

Manhattan Apartment Building
$10,000 minimum investment
Sponsor/General Partner is an experienced property manager and Real Estate Broker in New York City
Investors will own over 85% of the property

Kafarski Partnership Limited Partnership
Robert J. Kafarski, General Partner
10 West 172nd Street, New York, N.Y. 10032
(212) 795-5271

This advertisement is not an offering. No offering is made except by a prospectus filed with the Bureau of Securities, Department of Law and Public Safety of the State of New Jersey. The Bureau of Securities has not passed on or endorsed the merits of this offering.

WE ARE SPECIALISTS
in
PUBLIC RELATIONS
and
MARKETING

FOR THE MEDICAL PROFESSION
for a confidential interview call
(201) 531-7080

phyllis kessel associates
780 West Park Avenue, Oakhurst, NJ 07755

MEDICAL COMPUTERS

DEC - IBM - TELEVIDEO
ALTOS - NCR

THINKING OF COMPUTERIZING YOUR PRACTICE?

ML MEDICAL COMPUTER SPECIALISTS offers a wide variety of hardware/software configurations for every medical office, hospital and clinic application.

- AUTOMATIC INSURANCE FORM PREPARATION
- ACCOUNTS RECEIVABLE CONTROL
- AUTOMATIC PATIENT RECALL
- PRACTICE MANAGEMENT REPORTS
- CLINICAL RECORDS
- ACCOUNTS PAYABLE
- APPOINTMENT SCHEDULING
- ELECTRONIC CLAIMS SUBMISSION
- WORD PROCESSING
- MEDICARE/MEDICAID BILLING
- GENERAL LEDGER
- INVENTORY

UNIX SOFTWARE AVAILABLE FOR ALTOS AND NCR
MUMPS SOFTWARE AVAILABLE FOR DEC

SPECIALISTS IN MULTI-USER, MULTI-TASKING DATA-BASE MANAGEMENT SYSTEMS.

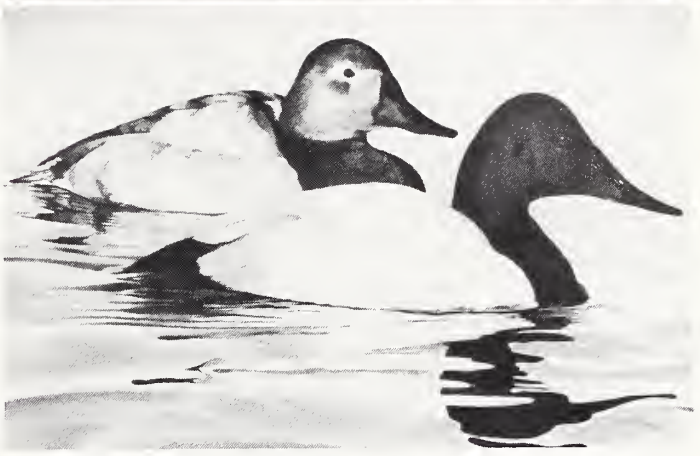
FBL

PROVIDING YOU WITH OVER 15 YEARS OF MEDICAL COMPUTER EXPERIENCE

CONSULTING SERVICE AVAILABLE

ROUTE 46W, FAIRFIELD, N.J. 07006 201-882-9210

"FIRST OF STATE" 1984 NEW JERSEY DUCK STAMP PRINT



Federal and state duck stamp prints are among the most desired collections in the U.S. The federal program is now 51 years old and is worth in excess of $80,000.00! A complete set of "first of state" duck stamp print is worth $16,000.00! Now New Jersey is offering their "first". The design is of a pair of Canvasbacks resting in water. Tom Hirata's painting is crisp, clear and classic!

A framed New Jersey Duck Stamp Print is a perfect addition to your home or office.

Call collect (609) 983-3771

Ask published and national authority Joe McCaddin for the possible tax advantages in collecting duck stamp prints.

MARLTON SPORT 'N WILDLIFE GALLERY



2 North Maple Ave.
Marlton, NJ 08053
(609) 983-3771

Print with two mint stamps $142.50 _____
Executive "color" Remarque Edition w/mints w/signed w/medallion & rem. $561.50 _____

**Framing—Two stamp openings $ 80.00*
Executive Edition $110.00

Mail Order—Add $7.50 for framed UPS delivery
Add $5.00 for unframed UPS delivery

Signature _____
Name _____ Phone _____
Address _____
City _____ State _____ Zip _____
Credit Card # _____ Exp. Date _____

VISA/MC Accepted

*All matting is to museum specifications with hand-stained Walnut. Medallion editions will be framed in Mahogany with gold lip to accent the medallion.

Microsurgical Resection of AV Malformations from Vital Areas of the Brain

Otakar R. Hubschmann, M.D., and Abbott J. Krieger, M.D., Newark*

Cerebral arteriovenous malformations may cause spontaneous intracerebral hemorrhage resulting in death or severe disability. Modern microsurgical techniques and neuroanesthesia allow for the resection of AVMs from vital areas of the brain without an increase in neurological deficit as a result of surgery.

Arteriovenous malformations (AVM) of the brain are one of several causes of a spontaneous intracerebral hemorrhage. Unlike the more common spontaneous hypertensive hemorrhage or ruptured aneurysm, the presence of AVM often is heralded by recurrent headaches or seizures prior to rupture.[1] The importance of recognizing these "warning" symptoms has increased recently as new microsurgical techniques allow the resection of AVMs prior to their rupture even from areas previously considered inoperable.

The surgical resection of these lesions has attained even greater significance recently since it has been recognized that, in addition to a life-threatening intracerebral hemorrhage, a dementia-like syndrome, thought to be caused by the pulsatile force of the AVM, relative ischemia of the normal brain in the vicinity caused by the shunting of blood through the AVM, or both, add to the total disability over a period of years.

The new aggressive approach to the treatment adopted at our institution has been directed not only to AVMs located in the "silent" areas, but also to those located in critical areas of the brain. Our experience, along with that of others who have adopted a similar approach, indicates that resectioning of an AVM from a vital area can be accomplished with no mortality and little additional morbidity.[2]

This report describes our experience with seven patients who have been operated on successfully using modern microsurgical techniques, some of which h been developed at our institution.

MATERIALS AND METHODS

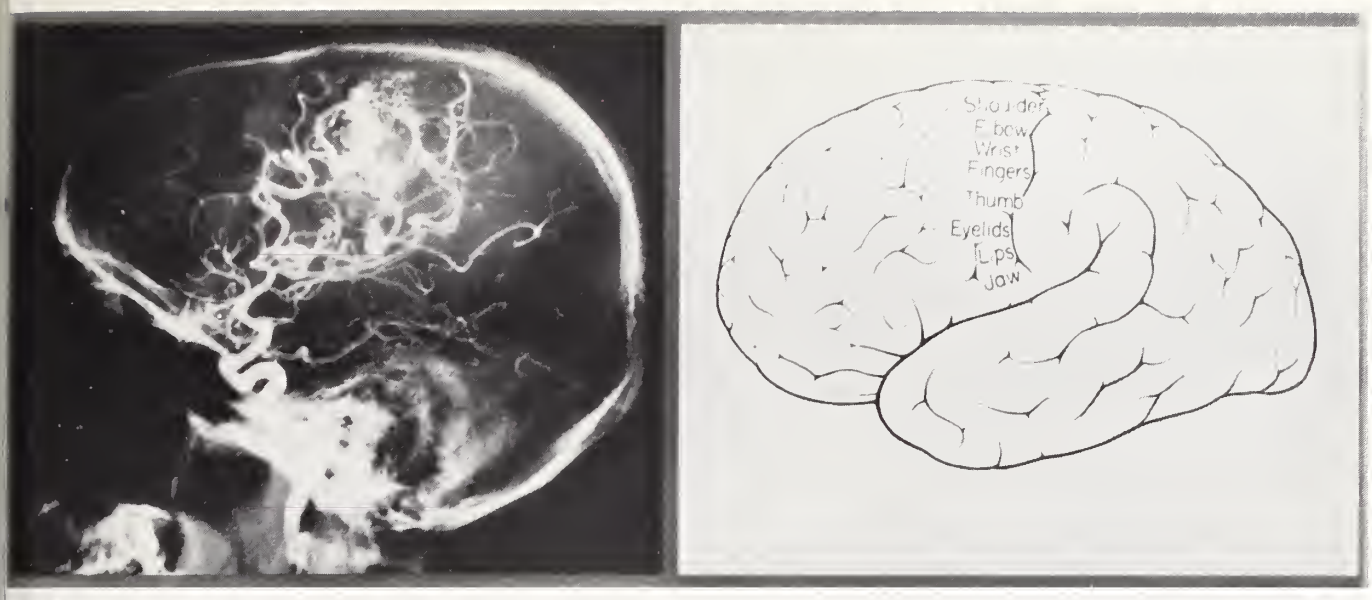
Seven patients with cerebral arteriovenous malformation (AVMs) in the motor area (3), the spe area (3), and the close vicinity of the internal capsu (1) were operated on. All patients were followed b neurologist both pre- and postoperatively. P operative angiograms demonstrating a total resect of the AVM were performed on each patient and viewed by a neuroradiologist. Age, sex, location of AVM, and postoperative results at six months are su marized in the Table. The following are case rep on four of these patients.

CASE REPORT 1

A 33-year-old, right-handed male presented wit a history of several years of headaches and seizures, a a recent subarachnoid hemorrhage which nece tated his admission.

He had only a mild hemiparesis (4/5) in the proxi muscles of the upper right extremity, hyperrefle and minimal spasticity. There was, however, a sig

*Dr. Hubschmann is Associate Professor and Dr. Krieg Professor and Chief, Section of Neurological Surgery, UMD New Jersey Medical School, Newark. Correspondence ma addressed to Dr. Hubschmann, UMDNJ-New Jersey Med School, 100 Bergen Street, M.S.B.H.-592, Newark, NJ 07



igure 1—The arterial phase of cerebral angiogram showing an AVM located within the motor strip (left). The schematic rawing of the somatotopic representation within the motor strip is on the right.



'igure 2—Preoperative angiogram of the same patient on the left showing the AVM. On the right is a postoperative ngiogram showing a total resection of the AVM and preservation of normal cerebral vasculature.

ıt degree of functional impairment of the hand, ·cifically, clumsiness of the fingers and thumb dur- ; rapid alternating movements. The angiogram re- ıls the relationship of the AVM to the motor strip Figure 1. A total resection of the AVM was achieved gure 2). After surgery, the patient exhibited a total miplegia of the arm, the face, and the leg, although was fully awake. The initial return of function began the legs and proximal muscles of the upper extremi- ɔn the fourth day; in two weeks, the patient was able walk with minimal assistance and lift the arm about °. At six weeks, he had findings similar to the ·operative ones except for the hand function which nained severely impaired although he could use the nd to feed himself. At six months, his neurological ımination was virtually the same as preoperatively, hough the hyperreflexia and the spasticity were newhat greater than before surgery.

CASE REPORT 2

A 32-year-old black female was admitted after the sudden onset of severe headaches and the rapid development of a flaccid left lower extremity monoplegia with only minimal drift of the left upper extremity and total sparing of the face. A CT brain scan showed a hematoma in the medial aspect of the hemisphere and an AVM.

At surgery, the main draining vein was followed to the arterial portion of the lesion and the whole AVM was identified and totally resected. After surgery, the patient awoke rapidly with a total hemiplegia on the left including face, arm, and leg equally. The full return of function to the face and the upper extremity was complete within 24 hours and she could walk unaided in two weeks. At six months, her findings were limited to a minimal weakness of the lower extremities,



Figure 3—Cerebral angiogram showing an AVM located in the receptive speech area (left). An anatomical drawing of th reported speech area is presented to the right (from case report 3).

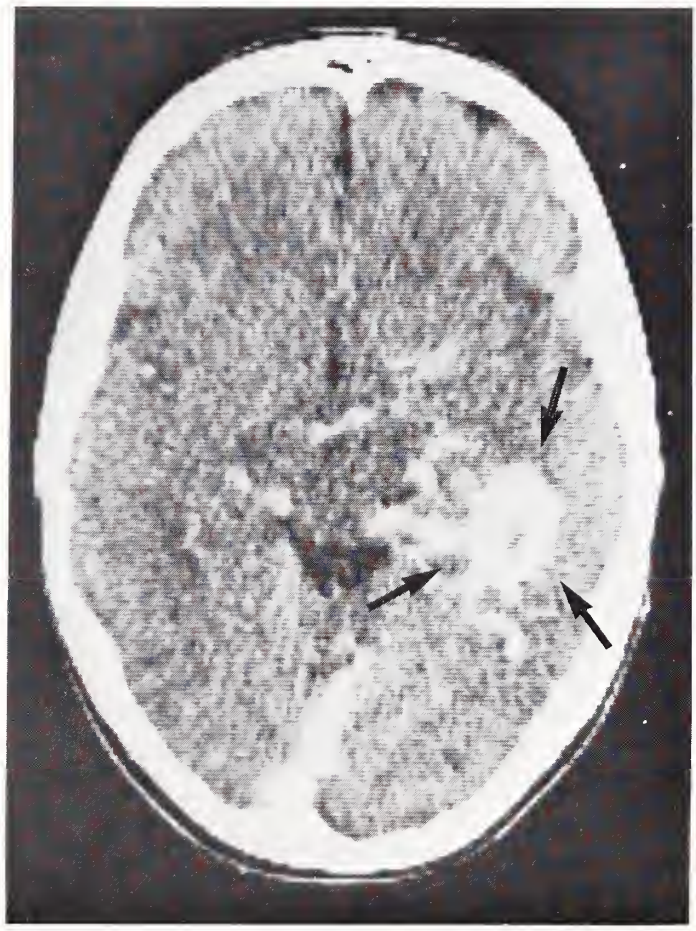


Figure 4—CT brain scan showing a large AVM in the left temporal lobe.

characterized primarily by a 5/5 left ileopsoas weakness, hyperreflexia, and an upgoing toe on that side. Functionally, there was only a barely noticeable limp.

CASE REPORT 3

A 52-year-old female with a long history of headaches and seizures had a positive CT brain scan during a routine evaluation. Examination was entirely normal including bedside testing for aphasia. The spinal fluid was normal. Cerebral angiogram revealed a large AVM located in the left posterior part of the middle and superior temporal gyrus, extending toward the angular gyrus (Figure 3). At surgery, a total resection of the AVM was achieved. The patient woke promptly f anesthesia with no neurological deficit. Bedside t ing for aphasia on the second postoperative day unchanged from preoperatively. She remai asymptomatic at six months followup.

CASE REPORT 4

A 58-year-old man had a history of several year headaches and seizures that recently had increase frequency. CT brain scan demonstrated a large A located in the left posterior temporal lobe (Figure Cerebral angiogram confirmed the presence of an tensive AVM in the temporal and parietal lobes. T removal of the AVM was achieved. Postoperatively, patient did well; he was afebrile but had a signific receptive dysphasia. CT brain scan showed evidenc postoperative swelling which persisted for sev weeks. The dysphasia gradually improved. Six we after surgery, a drainage from the wound occurred. cultures were positive and the infected bone flap removed. At surgery, an epidural collection of pus c municating with a small intracerebral extension, evacuated and he was treated with intravenous a biotics. Postoperatively, his dysphasia rapidly proved. Four months later, he was readmitted fo cranioplasty. His postoperative course was uneventf The cosmetic results were excellent. There was evidence of dysphasia or any other neurological pairment at the time of discharge.

DISCUSSION

Ruptured cerebral arteriovenous malformatio (AVMs) may cause a devastating neurological def from local brain destruction or death. On occasi unruptured AVMs may cause, in addition to seizu and/or headaches, a progressive dementia-like s drome usually ascribed to a relative ischemia of brain which is caused by a diversion of blood from normal brain into an AVM. The mortality and morbi ty of an AVM is greatest when it is located in vital ar since even a small hemorrhage, well tolerated in sil areas, may lead to a devastating neurological defi The likelihood of bleeding causing serious neurologi problems or death increases markedly when the c

TABLE

*Patient Results**

Age (years)	Sex	Preoperative Symptoms	Location of AVM	Postoperative (Six-month activity)
46	F	TIA, speech arrest, SAH	Left angular-middle temporal gyrus	No deficit, normal activity
42	M	SAH, transient expressive aphasia	Left middle frontal gyrus	No deficit, normal activity
12	M	Intracerebral hematoma, aphasia, complete right hemiplegia, and coma	Left middle frontal gyrus	No dysphasia on routine testing, mild right hemiparesis, attends school and plays soccer
32	M	TIAs, SAH, 4/5 right hemiparesis	Left motor cortex	Mild right hemiparesis (4/5A L), unemployed, normal recreational activity
28	F	Intracerebral hematoma, right lower extremity monoplegia, mild (5/5) right upper extremity paresis	Left motor cortex	Minimal (5/5) low extremity monoparesis, unemployed, drug addict, normal recreational activity
58	M	Intracerebral hematoma, left hemiplegia, coma	Right motor cortex	Left hemiparesis, 2/5 left upper and 4/5 left lower extremities
56	M	Seizures, headaches	Left temporal lobe	Asymptomatic, No asphasia

TIA: transient ischemic attack; SAH: subarachnoid hemorrhage.
*Grading system = 5/5: full strength; 0/5: total inability to move.

tion exists in a young patient with a longer life expectancy. The best candidates for surgery are those where ne risks are the greatest, i.e. young people with AVMs n vital areas who can be operated on prior to their eeding.

Since the danger of bleeding from an AVM persists ith its incomplete obliteration, often the case with nbolization treatment, a complete surgical excision the ideal treatment of choice.

Incomplete obliteration often is the case with emolization, particularily when multiple feeders are supplying the AVM. During embolization, small particles r rapidly setting glues, either alone or in combination, re used. A catheterization of the main feeding vessels as become possible in the hands of a few experts in his country and abroad. The high velocity flow nrough the AVM assures that initially all the particles nter the AVM. Once a significant portion of the AVM s obliterated, however, the flow relationships change nd at some point the flow through the AVM is not ignificantly different than through the normal brain. This may result in the ability to occlude only the main eeder as subsequent injections of the embolizing ubstance may result in occlusion of normal vessels. Unfortunately, incompletely obliterated AVMs are nown to regrow and their partial occlusion does not essen the risk of a bleed.

Although surgical results in the past always have not eflected the expectations based on the pathological analysis, McCormick and others have pointed out that there is a strong theoretical basis for a total resectability of most AVMs, regardless of their location.[3]

The AVMs are congenital anomalies resulting from the lack of development of a capillary interface between the arteries and veins. As a result, there is a markedly decreased resistance to the blood flow in the system which results in shunting of blood from normal areas producing a separate high flow-low resistance system in the AVM. This contributes to continuous enlargement of this system throughout a lifetime, and leads to a rupture and bleeding which is the primary cause of mortality and morbidity. The main vessels supplying the AVM usually do not supply normal brain structures and conversely, normal brain tissue, usually is not present within an AVM. McCormick has shown that abnormal neurons and increased glial population are sometimes found within the AVM while a plane of gliotic scar, often laden with hemosiderin, separates the AVM from normal brain tissue. Theoretically, an AVM safely can be resected if the surgeon is able to obliterate only the vessels supplying the AVM without occluding the normal vessels in the vicinity, and providing the resection is within the gliotic plane surrounding the AVM. Despite the sound theoretical base for a successful surgical resection, surgery for AVMs remains a formidable task and should be performed by experienced microvascular neurosurgeons at institutions with adequate technological support.

Our results, and those of others, indicate that resection, even of formidable AVMs, can be accomplished without mortality and without producing significant long-term morbidity. The neurological deficit that all patients (with the exception of one) experienced after surgery lasted between 24 hours and seven days, and eventually disappeared in all. This was caused by the cellular dysfunction of the cortical cells induced by the necessary mechanical manipulation at surgery, rather than by an injury to important vascular structures. None of the patients has a neurological deficit that was worse after surgery than preoperatively and several, in whom there was a deficit due to hematoma, improved dramatically postoperatively.

Based on our results, and the increasing number of excellent results of surgical resections of AVMs from vital areas of the brain as reported in the literature, we feel that an aggressive surgical approach is i dicated in carefully selected AVMs. With the increas technical ability of neurosurgeons specializing microsurgery and improved preoperative and po operative support, more and more patients who und go operative resection of an AVM will have excell results which will eliminate the ever-present dange a neurological deficit or death caused by a sudd rupture of an unoperated AVM.

REFERENCES

1. Stein BM, Wolpert SM: Arteriovenous malformations the brain *Arch Neurol* 37:1-5, 1980.
2. Kunc Z: Surgery of arteriovenous malformations in speech and motor-sensory regions. *J Neurosurg* 40:293-3 1979.
3. McCormick WF: The pathology of vascular ("arte venous") malformations. *J Neurosurg* 24:807-816, 1966.

FFECTS OF AIDS ON VARIOUS ASPECTS OF BLOOD BANKING

MERCY KURIYAN, M.D., FREDERICK MUSCHENHEIM, M.D., CELSO BIANCO, M.D., NEW BRUNSWICK*

Reports about acquired immunodeficiency syndrome (AIDS) have caused anxiety in prospective recipients of blood and blood products. Physicians should remember that the risk of AIDS from transfusion is much smaller than that of other known risks. Judicial use of blood and blood components and encouraging healthy individuals to donate are the preventive measures.

Information and misinformation about acquired immunodeficiency syndrome (AIDS), a dise of unknown etiology, has been reported by the dia. This has resulted in widespread anxiety in proctive recipients of blood transfusions and even has to misconceptions regarding the safety of blood nations.

ARS OF AIDS IN DONOR RECIPIENTS

A Roper organization survey of a nationwide repentative sample of 2,000 adults, age 18 and over, ealed that 50 percent of the survey population bees that receiving a blood transfusion can cause DS. The poll also found that nearly one in four nericans questioned incorrectly thinks that donatg blood for transfusion to a blood bank can cause DS.[1]

SK OF AIDS FROM BLOOD AND ITS PRODUCTS

Epidemiologic data suggest that there may be some k of transmitting AIDS by transfusion of blood or components. AIDS has occurred in patients with nophilia. Seventeen cases among the approximately 000 such patients in the United States have been orted.[2] The hemophiliac patients who contracted DS all had been treated with large doses of comrcially prepared factor VIII concentrates derived nost exclusively from paid donors numbering many usands for each lot. Studies have shown reduction of T helper/T suppressor cell ratios in patients receiving lyophilized concentrate, but not in patients treated with cryoprecipitated antihemophiliac globulin prepared from single volunteer donors.[3-5] However, more recent surveys indicate that a large number of persons with hemophilia, regardless of the source of factor VIII have abnormalities of helper/suppressor ratios. Transfusion of blood or components from single donors also have been suspected in the transmission of AIDS. Reports of 15 AIDS cases in adult transfusion recipients who are not members of the high-risk group and which comprise 1 percent of total AIDS cases now are under investigation.[6,7] In these cases, diagnosis was made one to three years after transfusion with a median of 18 months. The number of donors per patient ranged from 2 to 42 with a median of 20 donors per AIDS patient. In 7 of these cases, 1 of the donors either belonged to a high-risk group or had low T helper/T suppressor ratios. Control studies have not yet been performed. However, in none of these cases has a blood donor with AIDS been identified. The only case of transfusion-associated AIDS was described in a 20-month old infant who received a unit of platelets from a donor who developed AIDS 7 months after

*Dr. Kuriyan is Director, New Jersey Blood Services; Dr. Muschenheim is Director of Laboratories, Oneida Hospital, New York; and Dr. Bianco is Director of Research and Development, Greater New York Blood Program. Correspondence may be addressed to Dr. Kuriyan, New Jersey Blood Services, 5-A Joyce Kilmer Avenue, New Brunswick, NJ 08901.

donating blood. The child underwent multiple double-exchange transfusions for hemolytic disease of the newborn, and received blood and blood products from 19 donors.[8]

Blood, platelet, and fresh frozen plasma transfusions from voluntcer donors have not been linked definitely to the development of AIDS in any of the more than 15 million transfusion recipients in the United States in the past three years. About 98 percent of the whole blood or blood components used for transfusion in the United States and 100 percent of that used in New Jersey come from volunteer donors.[9]

PRECAUTIONS IN BLOOD COLLECTION

To prevent possible transmission of AIDS by blood and its products, blood collection agencies around the country, including New Jersey, have instituted several public health measures based on recommendations of the United States Public Health Service.[10] These include educational programs to inform persons at high risk of AIDS to refrain from blood or plasma donations (Table 1). Medical screening of donors has been extended to exclude anyone with signs or symptoms associated with AIDS (Table 2). This has resulted in a 2 percent increase in donor deferral by medical history. The Greater New York Blood Program and its divisions have a unit-exclusion system which permits individuals in the high-risk group to designate their blood for research. Every donor is given a confidential form which summarizes current information on AIDS and lists the high-risk groups. The form allows him or her to confidentially designate their donation for research only and not for transfusion. These units, as well as those from donors who left the form blank are removed from inventory and are not distributed to hospitals. About 1.2 percent of persons who donated in New Jersey through this program over an eight-month period specified that their blood be used for research only. Individuals at high risk of exposure to AIDS have been most cooperative in voluntarily withholding their donation of blood for transfusion.

SURROGATE TESTING

No test yet has been found that reliably can screen blood donors for exposure to AIDS. One recent study suggests that acid-labile alpha interferon might prove to be an identifying marker in asymptomatic patients.[11] Other nonspecific tests to identify blood donors at risk for AIDS currently being evaluated include antibodies to core antigen of hepatitis B virus, antibodies to cytomegalovirus (CMV), T helper/ T suppressor cell ratios, alpha, thymosin, and Beta 2 microglobulin. These assays have been found abnormal in AIDS patients and some high-risk groups. However, none has been shown to detect a possible carrier state for AIDS.

PRECAUTIONS IN BLOOD USAGE

Additional caution in the use of blood and blood products by treating physicians is necessary when considering the known risks of transfusion (hepatitis, cytomegalovirus, malaria, and hemolytic reactions) and those under investigation, e.g. AIDS.

In mild hemophiliacs, cryoprecipitate is being recommended for use in factor replacement therapy.[12]

TABLE 1

*Persons at High Risk**

Risk Groups for AIDS	Cases	% o Tot
Homosexual or bisexual males	1909	71.
IV drug user, no history of homosexuality	460	17.
Haitian, no history of homosexuality or drug use	131	4.9
Hemophiliac	17	0.6
Other	161	6.0

*AIDS: Weekly Surveillance Report, CDC, November 7 1983.

TABLE 2

*AIDS—Related Donor Medical Screening**

1. Arm inspection and questioning for intravenous dr use
2. History of AIDS
3. Cough or upper respiratory infection
4. Persistent recurrent night sweats
5. Lymph node enlargement
6. Tumor-like nodules or lumps on skin
7. Persistent diarrhea
8. Fever
9. Unexplained weight loss

*Donors with a positive response are deferred.

TABLE 3

Requisites for Autologous Transfusion

1. Autologous transfusion request from physician
2. Written consent by donor-patient
3. Donor hemoglobin level of 11 g/dl or greater
4. Oral iron supplements when multiple phlebotomies needed
5. Identification tags for blood and components
6. Communication protocols to notify physician or hospital of presurgical autologous blood availability

TABLE 4

Hazards of Transfusion

Hemolytic reaction	1 in 2,500 to 4,500
Nonhemolytic reaction	1 to 3 percent frequen
Hypersensitivity dermal reactions	3 percent of transfusi s
Anaphylaxis, severe	Less than 1 in 20,000
Hepatitis B*	74 per million
Malaria	4.9 per million
Acquired immunodeficiency syndrome**	
Hemophiliac plus blood transfusion	1 per million
Blood transfusion only	1 in 2 million

**MMWR*, May 1983 (approximate estimate based on cas of hepatitis B reported post-transfusion), p. 2355.
**Forum—views and opinions, Bruce A. Lenes, CCBC Newsletter, June 10, 1983, p. 6.

actor VIII concentrates continue to be the mode of herapy for severe hemophilia. All elective surgical rocedures in these patients need to be evaluated with espect to advantages and disadvantages of delay. A ew heat-treated factor VIII concentrate (Hemophil T) as been licensed recently. This process may reduce he hepatitis risk associated with these derivatives but is unknown whether it will change the AIDS risk.

UTOLOGOUS DONATION

Autologous blood transfusion, especially for elective urgery, has been encouraged (Table 3). The use of utologous blood is ideal but feasible only in patients ho probably will not require much blood and whose ealth status permits blood donations. Generally, ood for autologous donation is taken from patients ith hematocrit of 34 percent (11 gm of hemoglobin) · higher, and at a frequency of about one unit per eek. Plastic, orthopedic, gynecological, and general urgery (e.g. cholecystectomy, mastectomy, or rostatectomy) are elective procedures for which dona- on from self is useful. Intraoperative and post- perative salvage using commercially available auto- ansfusion units have applications in elective ascular surgery and trauma cases.

ESIGNATED OR DIRECTED DONATIONS

Requests for use of donors selected by the potential cipient has been a sequela to the fear surrounding IDS. However, the major blood banking organiza- ons—the American Association of Blood Banks ABB), the American National Red Cross (ANRC), and e Council of Community Blood Centers (CCBC)—in joint statement "strongly recommended that directed nations programs not be conducted." There is no surance that such programs increase the safety of ood. Patient-selected donors are under pressure to ve blood and may not be as truthful about their embership in a high-risk group as a volunteer, un- mmitted donor. In addition, directed donations may srupt a smoothly functioning blood system.

EW JERSEY STATUS

The Blood Bank Task Force for New Jersey along ith the New Jersey Department of Health and Blood ank Association issued a similar statement discouraging directed donations.[13] They further concluded that available data support the fact that AIDS is not being spread by blood transfusion from volunteer donors, and that appropriate public health measures have been instituted by the region's blood collection facilities to protect the quality of the regional blood supply.

CONCLUSION

The practicing physician should remember that the risk of AIDS from transfusion is much smaller than that of the other potential risks (Table 4). Judicious use of blood and blood components and encouragement of the healthy individual to donate are the best preventive measures available.

REFERENCES

1. Roper Organization Poll, August 13-20, 1983.
2. Acquired Immunodeficiency Syndrome (AIDS): Weekly surveillance report, AIDS Activity, Center for Infectious Disease, Centers for Disease Control, November 7, 1983.
3. Lederman MM, Ratnoff OD, Schillian JJ, Jones PK, Schacter B: Impaired cell-mediated immunity in patients with classic hemophilia. *N Engl J Med* 308:79-82, 1983.
4. Menitove JE, Aster RH, Casper JT, et al.: T-lymphocyte subpopulations in patients with classic hemophilia treated with cryoprecipitate and lyophilized concentrates. *N Engl J Med* 308:83-86, 1983.
5. Goldsmith JC, et al.: T-lymphocyte subpopulation abnormalities apparently in healthy patients with hemophilia. *Ann Intern Med* 98:294-296, 1983.
6. Update: AIDS. *United States Morbidity & Mortality Weekly Report*, September 9, 1983.
7. Jett JR, Kuritsky JN, Katzmann JA, Homburger HA: Acquired immunodeficiency syndrome associated with product transfusion. *Ann Intern Med* 99:621-624, 1983.
8. Ammann AJ, Cowan, MJ, Wara DW, Weintrub P, Dutz S, Goldman H, Perkins HA: Acquired immunodeficiency in an infant: Possible transmission by means of blood products. *Lancet* 98:956-958, 1983.
9. State of New Jersey Department of Health: 1982 Statistical Summary of Blood Use in New Jersey.
10. Petriccian JC: Letter to all establishments collecting human blood for transfusion. Office of Biologics, FDA, March 24, 1983.
11. ME Eyster, et al.: Acid-labile alpha interferon: a possible preclinical marker for acquired immunodeficiency syndrome in hemophiliacs. *N Engl J Med* 309:583, 1983.
12. The National Hemophilia Foundation Medical and Scientific Advisory Council, January 14, 1983.
13. Statement of Blood Bank Task Force of New Jersey, June 30, 1983.

Androgen-Secreting Ovarian Tumors in Postmenopausal Women

William B. Ober, M.D., Hackensack*

Two patients with lipid cell tumors of the ovary demonstrate that radioimmunoassay for total serum testosterone is the best laboratory clue to androgenization and that radiologic studies may miss small ovarian tumors. The expense of endocrine testing requires physicians to select the tests most likely to provide decisive information.

The clinical syndrome of androgenization generally is well recognized. Such signs and symptoms as hirsutism, acne, temporal hair recession, hypertrophy of the clitoris, and a lowered tessitura are the effects of excess circulating androgen, chiefly testosterone, converted peripherally to dihydrotestosterone by 5-alpha-reductase at the target organs. In prepubertal girls and premenopausal women, the diagnostic possibilities are numerous, including micropolycystic ovaries, ovarian hyperthecosis, hyperplasia of the adrenal cortex, and other complex endocrine syndromes. In postmenopausal women, excess testosterone production virtually is limited to patients with benign or malignant adrenocortical tumors or with a few histological types of ovarian tumor that usually are benign. That exceptions occur should be noted: an androgenic thecoma,[1] a Krukenberg tumor metastatic from the colon or stomach with luteinized stroma,[2] and reports of other unexpected lesions.

Given today's techniques for testing steroid hormones and their metabolites and radiological techniques for localizing lesions, it seems possible to develop a simplified, cost-effective plan for investigating postmenopausal women who are androgenized and for determining the appropriate surgical approach.

CASE REPORT 1

A 71-year-old woman complained of hirsutism developing slowly over two years. Coarse dark hair fi appeared on the face; it grew slowly at first, then mo rapidly to the point where electrolysis was necessa During the previous six months, dark hair began appear on the chest. Neither recession of the hairli at the temples nor acne was present. Menarche beg at age 15, and menses were regular. She had sever pregnancies, none of which were carried to ter Menopause was at age 50 and without complicatio

Physical examination was normal except for slig enlargement of the clitoris. Abdominal hair was i creased over both lower quadrants. Table 1 lists e docrine determinations. Bimanual pelvic examinati disclosed a small mobile uterus; no adnexal mass w felt. A pelvic sonogram was normal. A CAT scan show normal adrenal glands. At laparotomy, the uterus w small and the ovaries were normal for age. No gro tumor was seen. Total abdominal hysterectomy a bilateral salpingo-oophorectomy were carried out. T right ovary measured 2.5 x 1.8 x 0.8 cm, and in i medulla was a spherical 1.4 cm, soft brown tum sharply circumscribed from the cortex which co pletely surrounded it. Microscopic examinati showed it to be composed of an admixture of mediu

*Dr. Ober is Director Emeritus, Department of Laboratori Hackensack Medical Center. Correspondence may be a dressed to Dr. Ober, Hackensack Medical Center, Departme of Pathology, Hackensack, NJ 07601.

TABLE 1

Endocrine Determinations

tudy	Value	Normal Range
erum testosterone	326 ng/dl	10 to 75
lasma DHEA-S	113 mcg/dl	50 to 230
SH	59 MIU/ml	2 to 22
H	48 MIU/ml	22 to 133
rolactin	4.3 ng/ml	6 to 30
SH	8 MU/ml	1 to 10
4	8.2 mcg/dl	4 to 13
3 uptake	42%	24 to 36
stradiol	8.8 ng/dl	3 to 5
4-hour urinary ree cortisol	44 mcg/dl	20 to 90

TABLE 2

Endocrine Determinations

tudy	Value	Normal Range
erum testosterone	379 ng/dl	20 to 150
lasma DHEA-S	380 mcg/dl	110 to 610
SH	77 MIU/ml	40 to 200
H	—	
rolactin	—	
SH	1.7 MU/ml	0 to 4.5
4	7 mcg/dl	4.5 to 12.5
3 uptake	28%	23 to 34
stradiol	—	
erum cortisol, 2.00 P.M.	13.5 mcg/dl	A.M. 7 to 25 P.M. 2 to 9

zed polyhedral cells with bright eosinophilic toplasm and larger polyhedral cells with clear toplasm (Figure 1). The former resembled luteinized lls; the latter resembled adrenocortical cells. Occasional transitional cells were seen. Crystalloids of einke were not identified. The overlying circumferential cortex was slightly thickened and hypercellular. he tumor was classified as a lipid cell tumor, stromal teoma type. Significant lesions were not present in e other organs.

One week after the operation the serum testosterone vel was 38 ng/dl (normal, 10 to 75 ng).

ASE REPORT 2

A 61-year-old woman complained of hoarseness that ad not been relieved by cough syrup. Her regular hysician recognized that the hoarseness represented lowering of her tessitura. She had been in good general health except for a cholecystectomy two years eviously. Menarche had occurred at age 11¼ and enses were regular. She was a gravida 3, para 3. enopause had occurred at age 53 and was accomnied by moderate metrorrhagia.

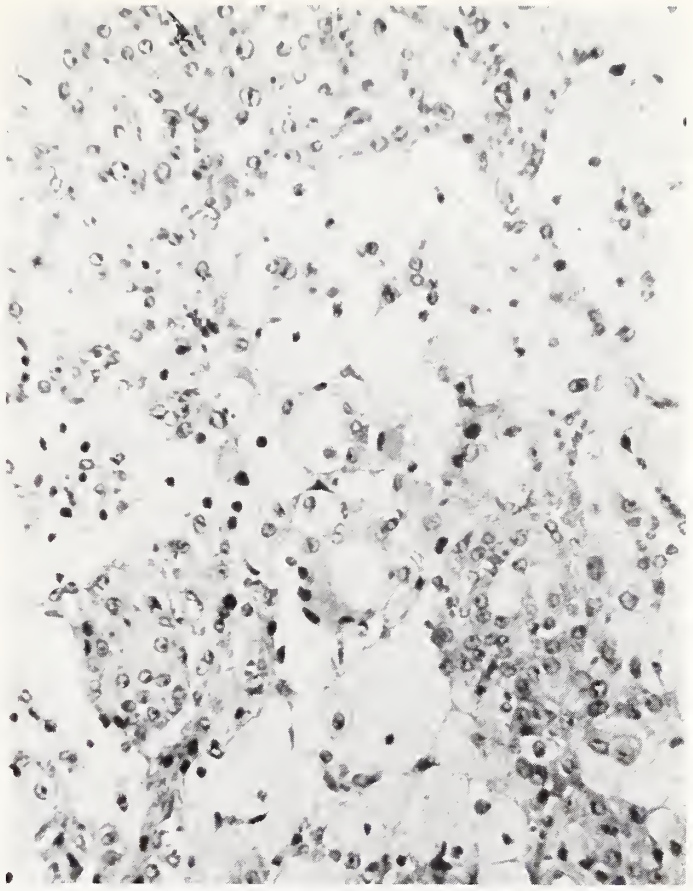


Figure 1—The ovarian tumor (case report 1) is composed of a mixture of small polyhedral cells with bright eosinophilic cytoplasm and large cells with foamy, finely vacuolated cytoplasm. Hematoxylin-eosin, 240 x.

Physical examination disclosed facial hirsutism and new growth of hair along the linea alba, lower abdomen, and upper thighs. The clitoris was conspicuously enlarged. The uterus was small and mobile; no adnexal mass was palpable. A pelvic sonogram was normal, and a CAT scan showed no enlargement of the adrenal glands. Table 2 lists endocrine determinations.

At laparotomy, the uterus contained a leiomyoma, and the tubes and ovaries were normal for age. Total abdominal hysterectomy and bilateral salpingo-oophorectomy were carried out. The left ovary measured 1.8 x 1.5 x 0.8 cm and contained a 1 cm discrete brown-tan nodule in its center. Microscopic examination revealed it to be composed of medium-sized polyhedral cells with eosinophilic cytoplasm and distinct cell membranes. A few cells contained small vacuoles in the cytoplasm and a few cells were large, polyhedral, and had a clear cytoplasm resembling adrenocortical cells. A fine capillary network was present. Crystalloids of Reinke were not found. The lesion was classified as a lipid cell tumor. The myometrium contained several medium-sized leiomyomata, and the endometrium was atrophic. No significant changes were seen in the other structures (Figure 2).

CLINICAL CONSIDERATIONS

Approximately 75 percent of women over 60 have an increased amount of hair on the upper lip or chin which is hypertrichosis, not clinical hirsutism.[5] The increase in hair is slight to moderate and stable. It is not accompanied by other signs of excess androgen production and is a cosmetic rather than a medical problem. Blood and urine androgens may be at or near

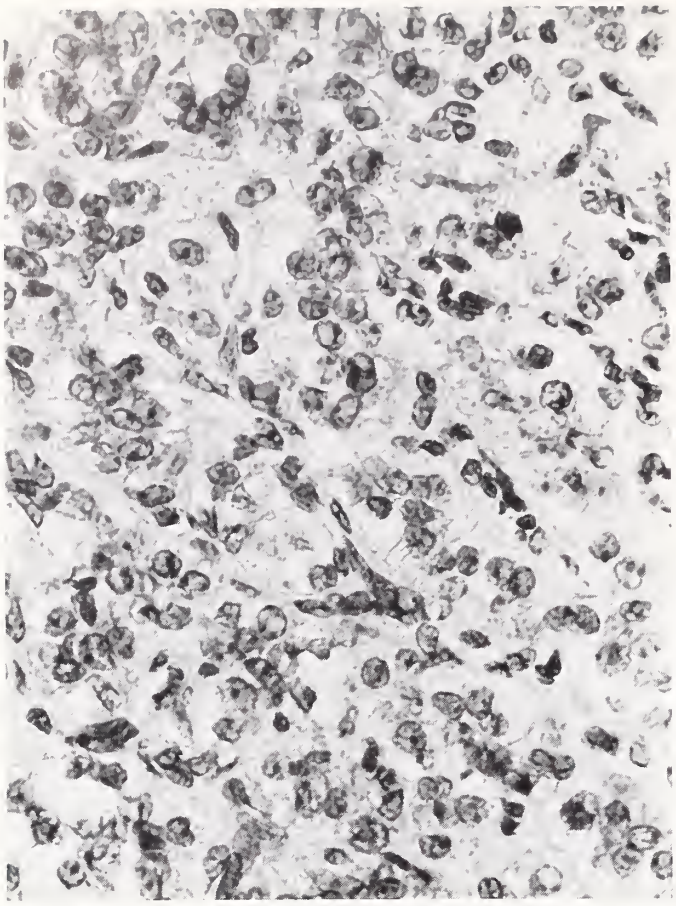


Figure 2—The ovarian tumor (case report 2) is composed of medium-sized polyhedral cells with finely vacuolated cytoplasm. Hematoxylin-eosin, 240 x.

the upper limit of normal for age, perhaps the result of ovarian cortico-stromal hyperplasia or postmenopausal increase in the number of ovarian hilus cells. Clinically significant hirsutism is progressive, albeit the rate of progression may be slow; sooner or later, it is accompanied by one or another physical sign of androgenization. Serum testosterone in such patients usually is elevated to double the upper limit of normal or higher and often is well into the male range. Patients react variably to progressive hirsutism. It usually has been present for several months, often over a year, before they seek medical attention. In case report 2, the patient consulted her doctor because she thought she was hoarse, though her degree of hirsutism was greater than in case report 1.

The problem facing the clinician is to decide whether the source of increased testosterone is ovarian or adrenal. Hyperthyroidism is not accompanied by hirsutism; only juvenile patients with hypothyroidism are hirsute, and then only to a minor degree. Some patients with Cushing's syndrome may be hirsute, but hypertension, plethora, and body habitus serve as ready points of distinction between that entity and androgenization from an ovarian or adrenocortical tumor. With few exceptions, an elevated serum testosterone level in a postmenopausal woman limits the diagnosis to a tumor of either of those two organs.

In prepubertal girls and women in the reproductive age, the range of diagnostic possibilities is wider and subtle alterations in the kinetics of androgen metabolism may be present.[4] Studies of production rate and metabolic clearance may be valuable in such patients. Selective sampling by catheterization of ovarian and adrenal veins and determination testosterone and androstenedione gradients may yie useful information in these younger women wi clinical androgenization.

If case reports in the literature are any guide, appears that although androgen-secreting tumors the ovary are uncommon, androgen-secreting tumo of the adrenal cortex are rare. It is not feasible to assi numerical values to their relative frequency but, giv a postmenopausal woman with an androgen-secreti tumor, the greater probability is that it will be locat in an ovary. Radiologic and laboratory investigation such patients should be designed to exclude adrenocortical tumor. Physical examination may n be helpful since most adrenal tumors are not lar enough to present as a flank mass and only about h the androgenic ovarian tumors can be palpated bimanual pelvic examination.

Adenomas and carcinomas of the adrenal cortex m occur at any age from infancy to old age. Fewer th 15 percent of them occur in postmenopausal wome Estrogen-secreting tumors produce precocious pub ty in girls, menstrual irregularities in adult wome and gynecomastia in males. Androgen-secreti tumors produce precocious puberty in boys; t tumors are clinically inconspicuous in adult mal and produce the androgenization syndrome in femal irrespective of age. About 25 percent of adrenocorti carcinomas secrete enough androgen to produce e docrine signs and symptoms.[5,6]

Androgen-secreting ovarian tumors likewise c occur at any age. The Sertoli-Leydig cell tumor is m frequent in younger than in older women, but abo 40 percent of the varieties of lipid cell tumor occur postmenopausal women.[16]

PATHOLOGIC CONSIDERATIONS

The archetypal adrenocortical adenoma is an e capsulated spherical or ovoid nodule with a soft yell to yellow-brown cut surface. The majority are over cm in diameter. They may weigh from 50 gm to o 1,000 gm. Microscopic examination usually reve polyhedral cells that closely resemble cells of t adrenal cortex with clear or vacuolated cytoplasm a well-defined cell membranes, arranged in a variety patterns. In a minority of specimens, bizarre cells wi hyperchromatic nuclei and an increased mitotic r are seen, and venous invasion may be demonstrab It is tempting to consider this as evidence of mal nancy but, in the majority of such exampl metastasis does not occur. One of the recurrent pr lems in endocrine neoplasms is to distinguish betwe adenomatous hyperplasia versus true adenoma a between adenomas with cell atypia versus t carcinoma. Adrenocortical carcinomas tend to larger than adenomas with weights over 500 gm uncommon. Their cell population may be mixed, polyhedral cells resembling adrenal cortex admix with fields of less well-differentiated cells, and with t usual microscopical stigmata of malignancy. Capsul invasion and infiltration of retroperitoneal fat by po ly differentiated cells occurs and is good evidence malignant potential, but metastatic deposits dem strated at the time of operation or subsequently pr ably are the only real proof of malignancy.

Occasional examples of testosterone-secreting adrenal tumors 4 cm in diameter or smaller have been reported.[7-10] The patients were from 20 months to 76 years old. In two patients, administration of HCG increased androgen production.[8,9]

Primary androgen-producing tumors of the ovary essentially are limited to two types, the Sertoli-Leydig cell tumor with its subtypes and the family of lipid cell tumors. Sertoli-Leydig cell tumors characteristically appear as rounded masses that may be yellow, orange, olive, brown, or variegated—the color depending on the proportions of neutral fat and lipochromes. They vary in size from 2 cm in diameter to 10 cm or more in diameter. The great majority occur in women under the age of 30; only about 10 percent occur in postmenopausal women. Well-differentiated examples almost always are benign, but Sertoli-Leydig cell tumors of intermediate or poor differentiation are capable of producing metastatic deposits.

The family of lipid cell tumors includes adrenal rest tumors, hilus cell tumors, stromal luteomas, and pure Leydig cell tumors without a Sertoli cell component. Because histological distinctions within this group are not precise, the neutral term "lipid cell tumor" has been recommended, though a more accurate term might be steroid cell tumor. They appear as soft spherical masses sharply demarcated from surrounding ovarian tissue and having the same range of colors as Sertoli-Leydig cell tumors. Those occurring in the broad ligament or mesovarium may well arise from adrenocortical rests that are common in those locations. The fact that some are associated with formes frustres of Cushing's disease cannot be taken as evidence of origin in an adrenal rest, but rather reflect the pattern of steroidogenesis in those tumors. Hilus cell and Leydig cell tumors can be identified specifically by demonstrating crystalloids of Reinke, but these intracytoplasmic protein crystals are inconstant, being found in only 40 percent of such tumors.[12] Over 60 percent of them occur in women under the age of 50; they are relatively more common in postmenopausal women than Sertoli-Leydig cell tumors. Only infrequently do lipid cell tumors exceed 6 cm in diameter; the majority are about 2 cm to 4 cm in size. It is impossible to distinguish between Sertoli-Leydig cell tumor and lipid cell tumor on clinical or endocrinological grounds.

RADIOLOGIC CONSIDERATIONS

Radiologic localization of an androgen-secreting tumor depends on demonstrating the image of a mass. Current CAT scan technology enables a radiologist to demonstrate with precision an adrenal mass as small as 1 cm in size. Pelvic sonography can demonstrate tumors 2 cm in size that distort the contour of an ovary. One limitation of pelvic sonography is that a subserosal leiomyoma of the uterus may be difficult to distinguish from an ovarian mass. Another problem is that a tumor-bearing ovary may prolapse into the pouch of Douglas so that its image is not separable sonographically from the uterus. The two cases presented here could not be detected by pelvic sonography because they were small and entirely within the substance of the ovary.

ENDOCRINE TESTING

Androgenization in a postmenopausal woman is the effect of excess testosterone production. This best is determined by radioimmunoassay for total serum testosterone. Unlike its precursor androstenedione, testosterone is not a 17-ketosteroid, and measuring urinary 17-ketosteroids may prove misleading. Approximately 98 percent of serum testosterone is bound to protein and the remainder is free. Although free testosterone can be measured, elevation of total testosterone suffices for diagnosis.

Any tumor that synthesizes testosterone can and often does synthesize estrogens by aromatization of the "A" ring in the steroid molecule. This is consistent with clinical evidence for estrogen production in adrenocortical tumors and in any of the various ovarian tumors mentioned. Immunohistochemical localization of steroids in Sertoli-Leydig cell tumors showed large amounts of testosterone in Leydig cells, less constant and smaller amounts in Sertoli cells, inconstant amounts of estradiol and estriol in both cell types, and even small amounts of progesterone in a few cases.[13] Any woman with elevated serum testosterone almost is certain to have elevated estrogen levels not only because of production in the tumor but also because of peripheral conversion of testosterone to estrogens. Determination of estrogen levels in urine or blood adds little information of value in an androgenized postmenopausal woman. The amount of estrogen usually is insufficient to produce cornification in vaginal exfoliative cytology.

Androgenization in a postmenopausal women is the effect of excess testosterone production.

It is not necessary to test thyroid function in a clinically euthyroid patient, nor is it appropriate to determine prolactin values in a woman without galactorrhea. Determination of pituitary gonadotropin levels adds little importance to the diagnosis. Though stimulation and suppression tests with chorionic gonadotropin may yield interesting biologic information about the dependency of steroid-producing tumors, they are not of diagnostic value.

Tests of adrenocortical function in this setting are essential. If they are within normal limits, one may be confident that the tumor is ovarian, except for the rare pure testosterone-secreting adrenocortical tumor. The most sensitive and specific test of adrenal androgen function is the plasma level of dehydroepiandrosterone sulfate (DS or DHEA-S) by radioimmunoassay.[14] Inasmuch as over 95 percent of circulating DHEA-S is from the adrenal cortex and less than 5 percent from gonadal sources, a significant elevation indicates the elevated testosterone is from the adrenal.[15] Only an occasional ovarian tumor will produce significant amounts of DHEA-S as well as testosterone. Like radioimmunoassay determinations of serum testosterone, plasma DHEA-S values are highly replicable.

Taking into account that as many as one-third of patients with androgen-secreting tumors may exhibit "Cushingoid" features, i.e. signs and symptoms less than full-blown Cushing's disease, it is not unreasonable to test glucocorticoid function by either a single determination of urinary-free cortisol in a 24-hour collection or a morning/evening measurement of serum cortisol. (In case report 2, a single mid-afternoon serum cortisol was used. This may be less sensitive than testing for diurnal decline, but the normal value gave reasonable assurance that adrenal glucocorticoid function was unimpaired.) The clinician must balance the inconvenience of two venipunctures for diurnal rhythm versus the nuisance and possible inaccuracy of collecting a 24-hour urine specimen. Scully has seen two lipid cell tumors of the ovary with metastases associated with florid Cushing's syndrome and elevated serum cortisol.[16]

An elegant, highly specific method of testing is retrograde venous catheterization with selective sampling from each ovarian and each adrenal vein.[17,18] Using this technique, all appropriate endocrine tests can be carried out at one time and the site of tumor localized. But it is an invasive method, and there often is technical difficulty in catheterizing the right adrenal vein. And, of course, it quadruples the cost of endocrine testing.

TABLE 3

1983 Charges for Selected Endocrine Tests by Three Major Reference Laboratories

	Laboratory 1	Laboratory 2	Laboratory 3
*Testosterone, total	$47.85	$52.00	$59.75
Testosterone, free	74.90	72.00	72.00
*DHEA-S,[+] plasma	35.00	45.00	60.00
*Cortisol, plasma[++]	28.00	33.50	34.50
Cortisol, free, urine	35.20	32.90	40.00
FSH	27.50	27.00	37.50
LH	28.00	26.40	37.50
Prolactin	40.00	39.00	52.00
TSH	34.00	33.00	39.50
T_3 uptake	6.95	7.50	14.00
T_4	8.05	7.75	16.00
Estrogens, total	35.20	32.90	49.00

All tests except T_3 uptake performed by radio immunoassay on serum, except as stated.

[+]: DHEA-S = dehydroepiandrosterone sulfate.

[++]: Requires two specimens, one at 8:00 A.M., one at 4.0 P.M.

COST EFFECTIVENESS

Endocrine testing is expensive so the judicious physician will select only those tests most likely to provide decisive diagnostic information. One should distinguish between diagnostic tests and those that merely provide information that is "interesting to know." The clinical pathology laboratory is not the place to satisfy medical curiosity at the expense of the patient or the insurance carrier. At present, except for special laboratories in research centers and university-affiliated hospitals, most of the infrequently requested endocrine tests are performed by commercial reference laboratories. These centers are equipped to receive specimens from widely distributed community and voluntary hospitals as well as from doctors' private offices. Most practicing physicians and nonuniversity hospitals do not have access to the specialized laboratories in research centers and university-affiliated hospitals. Most of the analytic procedures are carried out by radioimmunoassay. Although many community hospital laboratories are equipped to carry out radioimmunoassay on selected substances, the feasible range of tests they can offer is limited by the frequency with which they are requested. Assays for digoxin, insulin, T_4, TSH, and hepatitis antigens and antibodies frequently are requested and can be reported with replicable results and prompt turnaround time. Tests for polypeptide and steroid hormones, however, are less frequently ordered. Not only is accuracy reduced when uncommonly performed tests are carried out, but reagent costs render it uneconomical for community hospital laboratories to offer them.

Table 3 lists the charges for the tests mentioned as given in the fee schedules of three of the leading reference laboratories in this country. Three tests (total serum testosterone, plasma DHEA-S, and two determinations of plasma cortisol) range in total co from $138.85 to $188.75 with an average cost $163.87. These are the minimum tests needed evaluate an androgenized postmenopausal woma Also listed in Table 3 are the prices for free testo terone, pituitary gonadotropins, and thyroid functio as well as total estrogens and prolactin. By not orde ing these tests, the attending physician can save fro $213.55 to $285.50 with an average of $243.15. It b comes apparent that the checklist of tests offered reference laboratories is an open and tempting invit tion.

Except for the urinary-free cortisol assay, this di cussion deliberately has excluded tests for pituita and gonadal hormones on 24-hour urine specimen which invariably are more expensive than tests serum or plasma. Also, excluded is testing for estroge fractions because they are not relevant in women wit androgenization. The figures provided do not take in account the cost of obligatory routine urinalysi hemogram, and automated blood chemistry pane which are as conveniently performed in local labor tories as in reference laboratories. No data are give on the costs of an adrenal CAT scan or a pelvic son gram inasmuch as they vary widely depending on ge graphical location.

Perhaps it is timely to recall the comment made Mozart who, already an established composer at 2 first saw scores of Handel's music in the library Baron van Swieten: "He achieves the greatest effec by the simplest means."

REFERENCES

1. Case records of the Massachusetts General Hospit case 10-1980. *N Engl J Med* 302:621-626, 1980.

2. Clinico-Pathologic Conference: Knickerbocker Hospital. *State J Med* 59:1083-1090, 1959.
3. Melick R, Taft HP: Observations on body hair in old ople. *J Clin Endocrinol Metab* 19:1597-1607, 1959.
4. Kirschner MA, Bardin CW: Androgen production and tabolism in normal and virilized women. *Metabolism* :667-688, 1972.
5. Huvos AG, Hajdu SI, Brasfield RD, Foote FW Jr: Adrenal rtical carcinoma: Clinicopathologic study of 34 cases. *ncer* 25:354-361, 1970.
6. Hajjar RA, Kickey RC, Samaan NA: Adrenal cortical rcinoma: A study of 32 patients. *Cancer* 35:549-554, 1975.
7. Burr IM, Graham T, Sullivan J, Hartman WH, O'Neill J: testosterone-secreting tumor of the adrenal producing vir- zation in a female infant. *Lancet* 2:643-644, 1973.
8. Werk EE Jr, Sholiton LJ, Kalejs L: Testosterone-secreting renal adenoma under gonadotropin control. *N Engl J Med* 9:767-770, 1973.
9. Givens JR, Andersen RN, Wiser WL, Coleman SA, Fish SA: gonadotropin-responsive adrenocortical adenoma. *J Clin ndocrinol Metab* 38:126-133, 1974.
10. Larson BA, Vanderlaan WP, Judd HL, McCullough DL: testosterone-producing adrenal cortical adenoma in an lerly woman. *J Clin Endocrinol Metab* 42:882-887, 1976.
11. Scully RE: Tumors of the ovary and maldeveloped gonads. Atlas of tumor pathology, second series, fascicle 16. *Armed Forces Institute Pathology* 190-208, 1979.
12. Taylor HB, Norris HJ: Lipid cell tumors of the ovary. *Cancer* 20:1953-1962, 1967.
13. Kurman RJ, Andrade D, Gobelsmann U, Taylor CR: Immunohistochemical study of steroid localization in Sertoli-Leydig cell tumors of the ovary and testis. *Cancer* 42:1772-1783, 1978.
14. Korth-Schutz S, Levin LS, New MI: Dehydroepiandrosterone sulfate (DS) levels, a rapid test for abnormal adrenal androgen secretion. *J Clin Endocrinol Metab* 42:1005-1013, 1976.
15. Clinicopathologic Conference: Hirsutism progressing to virilization in an older woman. *Am J Med* 70:1255-1266, 1981
16. Scully RE: Personal communication.
17. Judd HL, Spore WW, Talmer LB, Rigg LA, Yen SCC, Benirschke K: Preoperative localization of a testosterone-secreting ovarian tumor by retrograde venous catheterization and selective sampling. *Am J Obstet Gynecol* 120:91-96, 1974.
18. Casthely S, Diaminidis HP, Pierre-Louis R: Hilar cell tumor of the ovary: Diagnostic value of plasma testosterone by selective ovarian vein catheterization. *Am J Obstet Gynecol* 129:108-110, 1977.

IMAGING: MAGNETIC RESONANCE IMAGING (MRI)*

KENNETH L. JEWEL, M.D., BARRY I. LOIGMAN, M.D., RICHARD F. MATTERN, M.D., STEVEN D. RICHMAN, M.D., CHARLES C. ROYER, M.D., CHARLES A. WHELAN, M.D., CALDWELL**

MRI is a new imaging modality which creates images of the head and body in any anatomic plane without the use of ionizing radiation or the need for intravenous contrast injection. Accepted as the diagnostic procedure of choice to evaluate the brain and spinal cord, the capability to image the remainder of the body with equal accuracy is viewed with great expectation.

Computerized imaging for medical diagnosis has been the major radiological advance of the last decade. The integration of computer techniques in x-ray computerized tomography (CT), nuclear medicine, real-time ultrasonography, and digital subtraction angiography (DSA) has allowed for remarkable improvements in diagnostic capabilities. A recent development, computerized magnetic resonance imaging (MRI), promises even greater advances in medical imaging.

Since the first MRI images in 1973,[1] rapid and significant progress has been made, so that today's images offer superb tomographic display with spatial resolution comparable to CT and unparalleled contrast resolution. The fact that these extraordinary images are created without the use of ionizing radiation and without the need for intravenous contrast material, adds considerably to the excitement and anticipation sweeping the medical community.

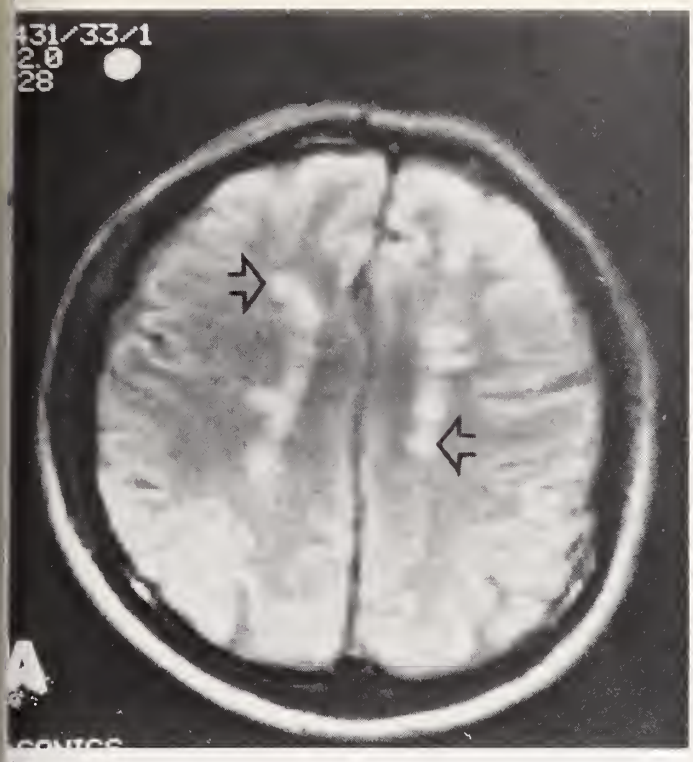
The purpose of this paper is to display normal neuroanatomy and representative neuropathologic states demonstrating the usefulness of clinical MRI. We emphasize that MRI is extremely useful for imaging the pelvis,[2,3] liver,[4] heart,[5] pancreas,[6] kidneys,[7] adrenal glands,[8] and musculoskeletal system.[9] This brief communication cannot encompass the already vast literature on MRI so the interested reader is referred to the many articles and texts on this subject.

METHOD

The magnetic resonance images displayed (Figure 1 to 7B) are obtained on a Diasonics 0.5 Tesla supe conductive magnet operating at a field strength of 3. Kgauss and corresponding to a resonant frequency 15 MHZ for hydrogen nuclei. The MR imaging syste is housed in a copper and aluminum-lined roo specially shielded against aberrant radio waves. Th radiofrequency (RF) coils are saddle shaped with a aperture of 25 cm for head imaging and 55 cm for bod imaging. Utilizing a multislice spin echo technique, typical imaging series with a repetition time of 2. seconds (TR = 2.0) takes approximately 17 minutes fo 20 image levels. In each plane, the first spin echo (T = 28 msec) and second echo (TE = 56 msec) ar analyzed. A typical patient study with images in co onal and transaxial planes requires about 30 minute Early examinations were performed as part of a Federa Drug Administration (FDA) approved investigationa protocol. Recently, the FDA granted formal approval t utilize MR imaging to produce cross-sectional display

*IMAGING is a new column presented in *The Journal* unde the direction of Judith K. Amorosa, M.D., Director of Medic Education, Department of Radiology, UMDNJ-Rutgers Med cal School.

**From the Montclair Radiological Associates. Co respondence may be addressed to Dr. Jewel, Montclair Radio logical Associates, 445 Bloomfield Avenue, Caldwell, N 07006.



igure 1A—A transaxial section through the centrum semi-vale demonstrating a rather typical demyelinating disease rocess pattern with multiple areas of increased NMR signal n the periventricular areas and central white matter (open rrows).



Figure 2A—A transaxial image demonstrates the presence of abnormal signal in the suprasellar cistern (open arrow). The juxtasellar internal carotid arteries as well as both orbits, lens structure, and optic nerves are depicted clearly.



Figure 1B—A midsagittal image demonstrating considerable cortical atrophy (open arrows) as well as clear delineation of the fourth ventricle (black arrowhead) as well as exquisite delineation of the normal aqueduct (small black arrow).



Figure 2B—A second echo sagittal image demonstrates the T2 weighted configuration of the chromophobe adenoma. The ballooned sellar component (open arrow) and the rounded suprasellar configuration (black arrowhead) are noted.

of the head and body recognizing this technique as a safe and effective medical advance. Patient cooperation and acceptance of the procedure have been excellent.

DISCUSSION

MRI appears to be superior to CT in evaluating most abnormalities of the nervous system. The technique can be applied to most patients with neurological complaints. Patients who are better studied with CT x-ray techniques are those on life-support systems, with cardiac pacemakers, and with intracranial aneurysm clips.

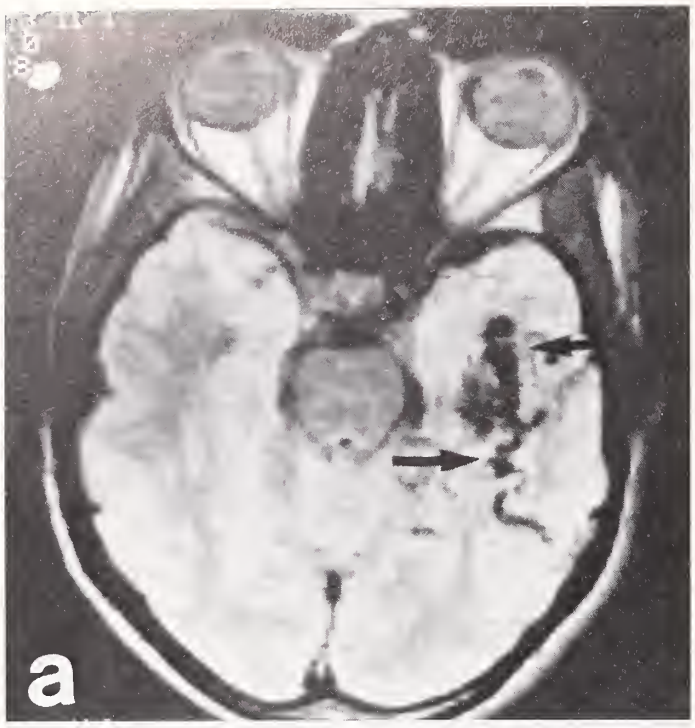


Figure 3A—A transaxial image through the orbits, midbrain, and temporal lobes and demonstrates the presence of multiple serpiginous low NMR signals seen in the left temporal lobe (black arrows). Again, the orbits, lens, medial, and lateral rectus muscles and optic nerves are seen.

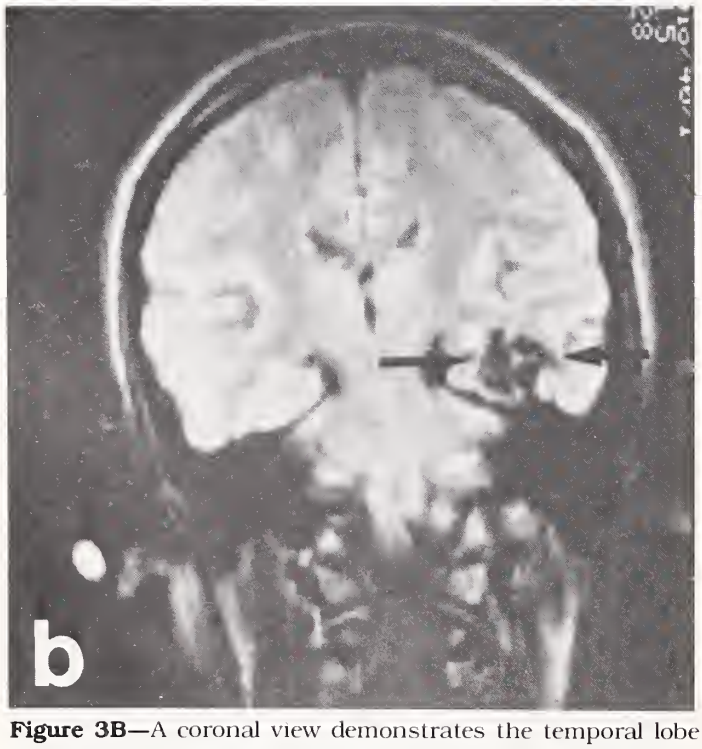


Figure 3B—A coronal view demonstrates the temporal lobe location of this angiographically documented arteriovenous malformation.

In contrast to x-ray computed tomography (CT), which relies on x-ray attenuation, MR images reflect the interaction of hydrogen protons with strong gradient magnetic fields and radiofrequency pulses. The proper selection of imaging sequences is challenging to the radiologist who must weigh signal to noise ratios, contrast and spatial resolution, imaging times, and imaging planes.

Marked improvement in the contrast resolution and

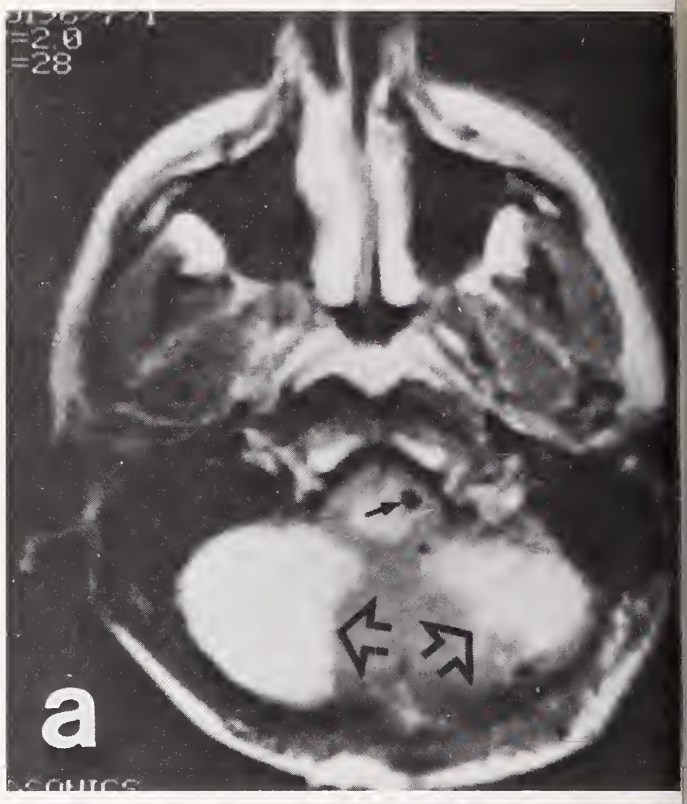


Figure 4A—This illustrates marked cerebellar hypoplasi Both cerebellar hemispheres (open arrows) are hypoplasti an enlarged cisterna magna is noted. The basilar artery (sma black arrow) is clearly demonstrated. The maxillary sinus and retroantral fat are clearly depicted.

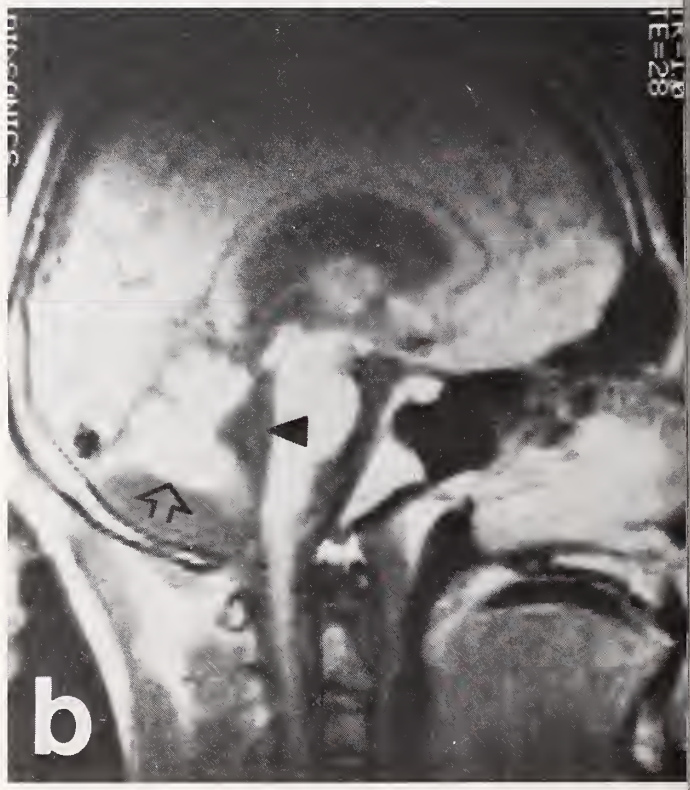


Figure 4B—An enlarged fourth ventricle (black arrowhead) a well as marked degree of cerebellar hypoplasia (open arrow The interpeduncular and prepontine cisterns also ar enlarged and the spinal cord is somewhat atrophic.

soft tissue discrimination are only two of the striking advantages of MRI. Several other factors herald an ex citing future. MR images are totally noninvasive and do not require the injection of iodinated contrast agents. The patient receives no exposure to ionizing

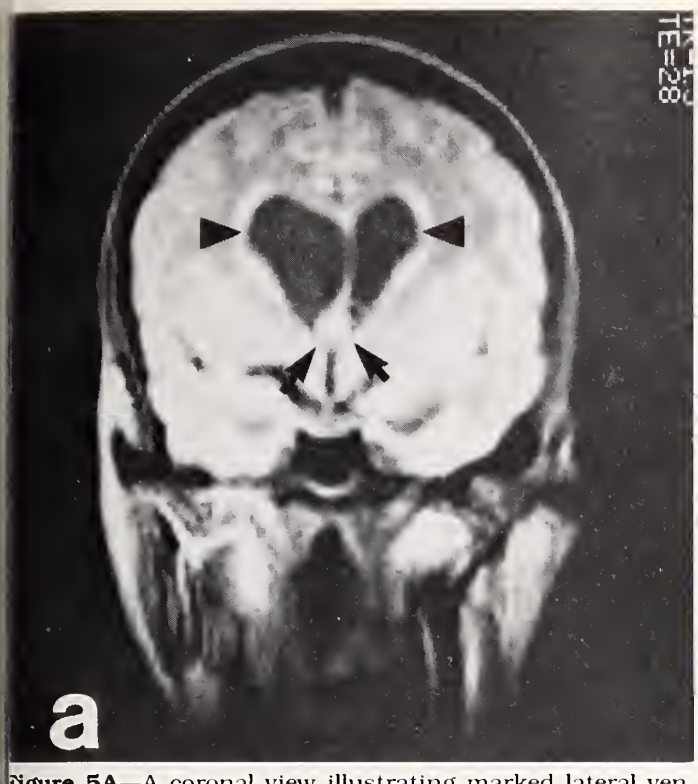


Figure 5A—A coronal view illustrating marked lateral ventricular enlargement (black arrowheads) with the presence of a high NMR signal area in the anterior superior aspect (black arrows) of the third ventricle typical in location for a colloid cyst.

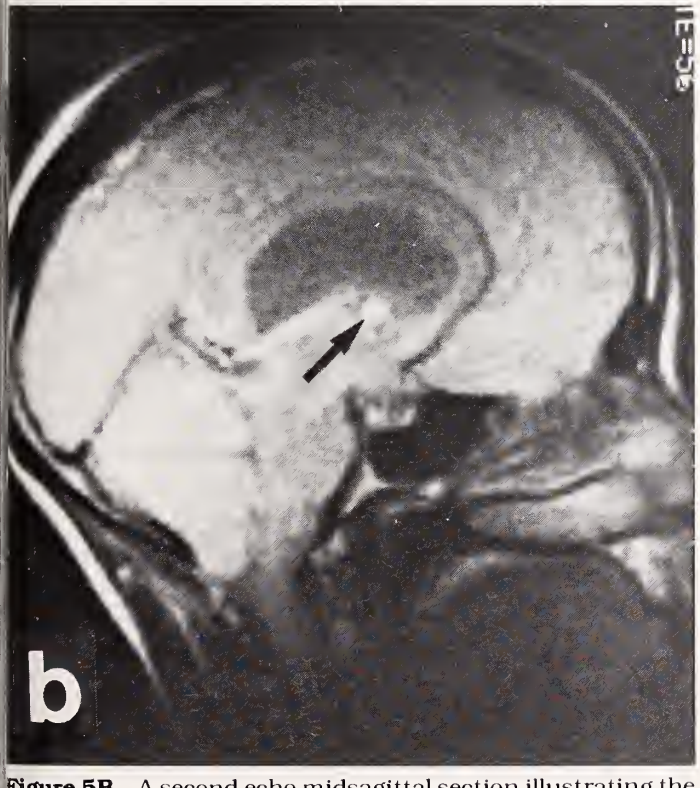


Figure 5B—A second echo midsagittal section illustrating the presence of the high NMR signal in the anterior superior aspect of the third ventricle (black arrow) typical in location for a colloid cyst. The anterior cerebral artery is seen as is the basilar artery.

radiation and there are no known biological hazards.[10,11] Projections are readily obtained directly in any plane and the image degradation commonly seen in CT reconstruction of sagittal images does not occur with MRI. The ability to visualize directly in coronal, sagittal, and axial planes, and the remarkable ease with which this can be accomplished, allows for greater precision in anatomic location. Bone artifacts are absent in MRI. This allows for clear visualization of many structures, e.g. posterior fossa, brain stem, spinal cord, which are less well seen by CT. Blood vessels are extremely well seen without the need for intravenous contrast material.[12,13]



Figure 6—Periventricular edema (open arrows) surrounding mildly dilated lateral ventricles.

It clearly has been documented that MRI is vastly superior to CT in the diagnosis of white matter diseases of brain[14] including multiple sclerosis, leukodystrophy, and Biswanger's disease. MRI is equal to or superior to CT in most intracranial pathological conditions.[15] In a series of 70 cases, MRI detected an abnormality missed with CT or showed more lesions than did CT in 16 patients[16] including metastatic disease, postinfectious states, and posterior fossa and brain stem pathology. Recently, reports of the usefulness of MRI in the diagnosis of head trauma including isodense subdural hematoma has been described.[17,18] Lesions of the spinal cord including syringomyelia and cord tumors are ideally visualized by MRI as well. Because MRI is free of biological hazards and is totally noninvasive, its usefulness as a screening procedure is unrivaled. In addition, its superb contrast resolution enables MRI to be an extremely sensitive diagnostic modality in imaging the brain and central nervous system.

REFERENCES

1. Lautebur PC: Image formation by induced local interactions: Examples employing nuclear magnetic resonance. *Nature* 242:190-191, 1973.

2. Hricak H, Williams RD, Spring DB, et al.: Anatomy and pathology of the male pelvis by magnetic resonance imaging. *AJR* 141:1101-1110, 1983.

3. Hricak H, Alpers C, Crooks LE, Sheldon PE: Magnetic resonance imaging of the female pelvis. *AJR* 141:1119-1128, 1983.

4. Smith FW, Mallard JR, Reed A, Hutchinson JMS: Nuclear magnetic resonance tomographic imaging in liver disease. *Lancet* 1:963-966, 1981.



Figure 7A—A transaxial view reveals the presence of a large area of increased NMR signal (small black arrows), the central portion of which reveals an area of some decreased NMR signal (open arrow). The lower NMR signal area corresponds to the actual neoplasm (glioblastoma) while the higher NMR signal corresponds to extensive surrounding cerebral edema. Enlarged frontal sinuses and periventricular edema also is noted.

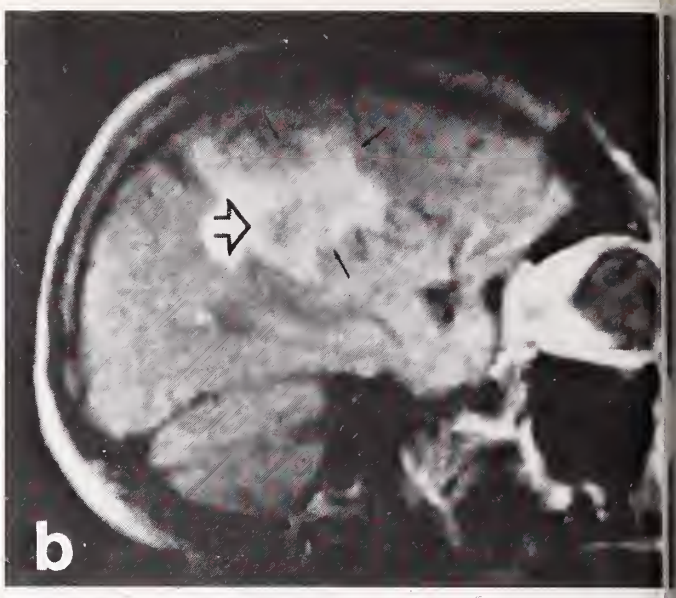


Figure 7B—A parasagittal view demonstrates the infiltrat high NMR signal seen as a result of this malignant tur (small black arrows) and again the area of decreased N signal corresponds to the area of actual neoplasia.

5. Lanzer P, Botvinick EH, Schiller NB, et al.: Cardiac imaging using gated magnetic resonance. *Radiology* 150:121-127, 1984.

6. Smith FW, Reid A, Hutchinson JMS, Mallard JR: Nuclear magnetic resonance imaging of the pancreas. *Radiology* 142:677-680, 1982.

7. Hricak H, Crooks LE, Sheldon PE, Kaufman L: Nuclear magnetic resonance imaging of the kidney. *Radiology* 146:425-432, 1983.

8. Moon KL, Hricak H, Crooks LE, et al.: Nuclear magnetic resonance imaging of the adrenal gland: A preliminary report. *Radiology* 147:155-160, 1983.

9. Moon KL, Genant HK, Helms CA, et al.: Musculoskeletal applications of nuclear magnetic resonance. *Radiology* 147:161-171, 1983.

10. Wolff S, Crooks LE, Brown P, et al.: Tests for DNA and chromosomal damage induced by nuclear magnetic resonance imaging. *Radiology* 136:707-710, 1980.

11. Schwartz JL, Crooks LE: NMR imaging produces no observable mutation or cytotoxicity in mammalion cells. *A* 180:707-710, 1980.

12. Kaufman L, Crooks LE, Sheldon PE, et al.: Evaluati of NMR imaging for detection and quantification of obstr tion in vessels. *Invest Radiol* 17:554-560, 1982.

13. Alfidi J, Haaga JR, El Yousef SJ, et al.: Prelimin experimental results in humans and animals with a sup conducting, whole body nuclear magnetic resonance scann *Radiology* 143:175-181, 1982.

14. Young IR, Randell CP, Kaplan PW, et al.: Nucl magnetic resonance imaging in white matter diseases of t brain using spin-echo sequences. *J Comput Assist Tom* 7:290-294, 1983.

15. Byddar GM, Steiner RE, Young IR, et al.: Clinical NM imaging of the brain: 140 cases. *AJR* 319:215-236, 1982

16. Brant-Zawadzki M, Davis PL, Crooks LE, et al.: NM demonstration of cerebral abnormalities: Comparison w CT. *AJR* 140:847-854, 1983.

17. Han JS, Kaufman B, Alfidi RJ, et al.: Head trauma eva ated by magnetic resonance and computed tomography: comparison. *Radiology* 150:71-77, 1984.

18. Sipponen JT, Sipponen RE, Sivula A: Chronic subdu hematoma: Demonstration by magnetic resonance. *Rad logy* 150:79-85, 1984.

Update: Immunizations During Pregnancy

Stephen R. Preblud, M.D., Kenneth J. Bart, M.D., Alan R. Hinman, M.D., Atlanta, GA*

In this essay, the authors clarify the Centers for Disease Control recommendations regarding rubella vaccination of postpubertal females.

This essay is in response to the article, "Guidelines for Immunization During Pregnancy," by Dreyfuss et al. in *The Journal* in July 1983. On page 512, it is stated: "The CDC currently recommends that rubella vaccine be administered only after pregnancy has been ruled out. . . ." While it has been some time since the article appeared, we think it is important to clarify the CDC recommendations regarding vaccination of postpubertal females.

The authors imply that some sort of test be performed to rule out pregnancy. However, as of 1978 the Immunization Practices Advisory Committee (ACIP) of the CDC has recommended: "In view of the importance of protecting this age group against rubella, asking females if they are pregnant, excluding those who are, and explaining the theoretical risks to the others are reasonable precautions in a rubella immunization program." Neither pregnancy testing nor prevaccination serologic screening routinely are recommended. These recommendations have been repeated in the ACIP statements that appeared subsequently,[1] the most recent being in the June 8, 1984, issue of the *MMWR*.[2]

The authors express concern about the teratogenic potential of the RA 27/3 vaccine licensed in the United States in 1979. Information published at the time that the article appeared in *The Journal*, but that was not cited, indicated that the RA 27/3 vaccine had no more teratogenic potential than the other previously available rubella vaccines.[3-5] As of December 1983 no CRS-like defects have been observed in 121 infants born to susceptible women who received the RA 27/3 vaccine within 3 months before or after the estimated date of conception.[6] Thus, the data continue to show that the fetal risk associated with the RA 27/3 vaccine "is so small as to be negligible and ordinarily should not be a reason to consider interruption of pregnancy."[2] Because of the theoretical risk of fetal defects, the vaccine still should not be given to women known to be pregnant.

Vaccination of children has resulted in a dramatic decrease in the reported incidence rates of rubella and congenital rubella syndrome (CRS) in this country.[7] The provisional 1983 totals for rubella (954 cases) and CRS (4 cases that are confirmed or compatible with the syndrome) represent alltime lows.[8,9] As vaccinated children enter the childbearing age, rubella and CRS will be eliminated. However, this process will take 10 to 30 years. In the meantime, a relatively small but preventable number of CRS cases will continue to occur, each with an estimated lifetime cost in excess

*From the Department of Health and Human Services, Centers for Disease Control, Atlanta, Georgia, where Dr. Preblud is Medical Epidemiologist, Dr. Bart is Chief, Surveillance, Investigations and Research Branch, and Dr. Hinman is Director, Division of Immunization, Center for Prevention Services.

of $200,000.[10] The continuing occurrence of rubella in childbearing age populations is a result of a failure either to have been infected or vaccinated. Approximately 10 to 15 percent of this population still is susceptible, a rate similar to that noted in prevaccine years.[7]

The elimination of CRS can be hastened by increasing our efforts to effectively vaccinate postpubertal individuals, especially women. Such efforts recently have resulted in a decline in the reported incidence rate of rubella in postpubertal persons.[8,9] An important element in this progress has been vaccinating this population according to ACIP guidelines for determining immunity, i.e. having written proof of vaccination on or after the first birthday or documentation of positive serologic testing.[2] Vaccine is indicated for all individuals lacking either of these two criteria of immunity (a physician's diagnosis of rubella is unreliable and is not acceptable for proof of immunity).

Great strides have been made in the control and eventual elimination of CRS. It is important to clarify for the readership what the current rubella vaccination recommendations are so vaccine may be given effectively to those most in need.

REFERENCES

1. Immunization Practices Advisory Committee: Rube prevention. *MMWR* 30:37-42, 47, 1981.
2. Immunization Practices Advisory Committee: Rube prevention. *MMWR* 33:301-10, 315-318, 1984.
3. Preblud SR, Stetler HC, Frank JA Jr, Greaves WL, Hi man AR, Herrmann KL: Fetal risk associated with rube vaccine. *JAMA* 246:1413-7, 1417, 1981.
4. Centers for Disease Control: Rubella vaccination duri pregnancy—United States, 1971-1981. *MMWR* 31:477-4 1982.
5. Centers for Disease Control: Rubella vaccination duri pregnancy—United States, 1971-1982. *MMWR* 32:429-4 1983.
6. Centers for Disease Control: Rubella vaccination duri pregnancy—United States, 1971-1983. *MMWR* 33:365-3 373, 1984.
7. Orenstein WA, Bart KJ, Hinman AR, et al.: The o portunity and obligation to eliminate rubella from the Unit States. *JAMA* 251:1988, 1984.
8. Centers for Disease Control: Rubella and congeni rubella—United States, 1980-1983. *MMWR* 32:505-510, 19
9. Centers for Disease Control: Rubella and congeni rubella—United States, 1983. *MMWR* 33:237-242, 247, 19
10. Koplan JP, White CC: An update of the benefits and c of measles and rubella immunization, in, proceedings of t symposium, "Conquest of Agents that Endanger the Brai Baltimore, MD, October 28-29, 1982 (in press).

Commentary: Update of Diagnostic Related Groups

Martin E. Johnson, Lawrenceville*

Under the Diagnosis Related Group (DRG) system, New Jersey hospitals are reimbursed on a fixed rate. DRGs have not proved their effectiveness or value. An evaluation of the system is needed.

The year 1979 ushered in a change in health care delivery for 20 hospitals in the state of New Jersey. It was the year the Yale School of Public Health's program of Diagnostic Related Groups (DRGs) system of payment for hospital care was to be given a field trial. The New Jersey Department of Health sought and received a $2 million federal grant in 1976 to fund an "experimental" application of the DRG concept. While the experiment never was completed as an objective study, the state's 104 general hospitals went on the DRG system in three groups between 1980 and 1982.

Under the DRG system, the hospitals no longer are reimbursed for what was spent to treat the patient. The payment is based on a fixed rate for each of the 467 categories of DRGs. Under this system, hospitals lose money if they spend more than the assigned rate and they keep the difference if they spend less than the assigned rate. This gives hospitals a financial incentive to be selective and cost conscious; but it does not assure optimal care and it could prejudice the treatment selected.

Early legislative activity coupled with unwarranted regulatory zeal brought about a statewide adoption of the DRGs without a definitive evaluation.

A former Commissioner of Health, who was a prime mover for the DRG system in New Jersey, with the use of some unusual mental gymnastics indicated it was "neither appropriate nor possible to evaluate the DRG system until all the hospitals have been on it for a full year." This philosophy flies in the face of all accepted procedures for orderly evaluation of a delivery system prior to full implementaton. To do so, the Department of Health applied for and received a five-year, $4 million federal grant to continue the experiment. The program still is to be given a valid evaluation even though it was introduced statewide in 1980.

The current Commissioner of Health, Dr. J. Richard Goldstein, has stated "The hospitals are responding to the DRGs cost-cutting incentives and patient care has not suffered." The credibility of this statement was challenged by Dr. Goldstein when he said that there is "no single measure of whether the system is working." He further stated the national rate of change in hospital operating expenses is the state's "yardstick for comparison" and that "we would like to do better than the national average"—something New Jersey was doing prior to the implementation of DRGs.

As mentioned in a commentary on DRGs that appeared in the May 1984 issue of *The Journal* of the Medical Society of New Jersey, Mr. Vincent Maressa, Executive Director of the Medical Society, indicated the rate of hospital care costs in New Jersey for six

*Mr. Johnson is Director of Public Affairs and Medical Education, MSNJ. Correspondence may be addressed to Mr. Johnson, MSNJ, Two Princess Road, Lawrenceville, NJ 08648.

years prior to the DRGs installation in New Jersey. The New Jersey hospitals averaged 3.5 percent below the national average. The first year after the program was used, New Jersey came in 3.4 percent below the national average; the second year New Jersey came in 4.7 percent below the national average. On the surface, this would look encouraging until you consider the fact that the national average of cost increase for that year was 1.7 percent more than the established trend had been.

The Department of Health stated that the first year of DRGs net patient service revenue increased 22.6 percent. The actual costs increased 13.6 percent. This reflects in a 36 percent or more increase in cost to the public. The second year, the net revenues increased by 14.8 percent and the costs went up 14.0 percent for a cost increase to the patient of 28.8 percent or more. It is unlikely that state and national bureaucrats will admit the error of their ways. Under such a situation it is inevitable that the DRG system will collapse. They will in all probability try to implicate the medical profession in the disaster to shift the blame from its rightful place.

There have been several articles in *The New York Times* of recent date that have pointed out the differences of opinion regarding the value of DRGs and its effect on hospital care. One of the articles, "Statistical Analysis Difficult," indicated the complexity of the New Jersey DRG system has created problems for those charged with running the program as well as those evaluating it. The difficulty in arriving at a viable statistical analysis was referred to by Dr. William Hsio, a Harvard University School of Public Healt economist. He indicated "a lot of effort went into im plementing the DRG program, but, not enough plan ning was done in how to evaluate the results." Th same article quoted Stanford Weiner, a political scien tist from M.I.T., as stating "It is striking that a progra now entering its fifth year, a program that involves $ billion in hospital reimbursements, that nothing clos to reliable numbers are available from either the stat or the federal government."

Dr. J. Richard Goldstein, Commissioner of Health, i the same article acknowledged that more attentio was given to how to implement the DRG program tha how to evaluate it. He stated, "This was typical of mos government-sponsored programs."

Dr. Frank J. Primich in a letter to the editor of *Th New York Times* referred to the April 2, 1984, editoria "Failure of a Hospital Diet." Dr. Primich indicated tha government, labor and management, and insuranc industry have promised more than they can provid

Recently, the Health Care Financing Administratio advised the Department of Health that the New Jerse DRG waiver is revoked, effective December 31, 198

What was born in confusion and raised in haste ha grown into a runaway monster without responsibilit or control.

Free enterprise does not mean "free lunch." Pro gramming of restrictive hospital health care withou a system of accountability that encompasses a aspects of the delivery of that care is sheer lunacy an typical of bureaucratic bungling. It is fraught wit danger and doomed to failure.

Trustees' Minutes; UMDNJ Notes; MSNJ Auxiliary; New Members; Tamisiea Award; Physicians Seeking Location in New Jersey

rustees' Minutes
uly 15, 1984

A regular meeting of the Board of rustees was held on Sunday, July 5, 1984, at the Executive Offices in awrenceville. Detailed minutes are n file with the secretary of your unty society. A summary of sigficant actions follows:

eport of the President . . .
.) State Board of Medical Exam-ers' Meeting on Chiropractic . . . oted that a proposal expanding the andards and scope of chiropractic as referred back to the State Board ommittee on Chiropractic for a de-rmination on appropriate tests to e performed by chiropractors.
:) Annual Meeting Scientific ession Format . . . Noted a sugges-on that scientific sessions at the nnual Meeting concentrate on only ne topic.

eport of the Executive irector . . .
.) MSNJ 1984 Membership . . . oted that as of June 30, 1984, embership was at 7,299. Noted the ossibility of including a request for payment of first-year dues with the membership application.
(2) MSNJ Financial Statements . . . Approved the unaudited financial statements for the period ending May 31, 1984.
(3) Legal Matters . . .
(a) SBME *v* Greco . . . Authorized MSNJ to join in the petition for certification in the Greco case.
(b) Federal Trade Commission . . . Noted a preliminary response has been filed with the Federal Trade Commission in response to their investigation of MSNJ, relating to the potential violation of price fixing and market restraint.
(c) Subordinated Loan Status . . . Noted final decision on subordinated loan litigation still is pending in Tax Court.
(4) Medicaid . . . Noted that a subcommittee of the Medicaid Cost Containment Committee has recommended that physicians' fees for ambulatory and office care be upgraded in accordance with the plan designed for Atlantic and Mercer counties; the subcommittee also has recommended reapplication to the federal government to institute the project.
(5) Medicare Fee Freeze . . . Agreed that the AMA should be requested to review the Medicare fee freeze carefully, and give consideration to the litigation of all appropriate issues on behalf of all U.S. physicians.
(6) Physician Supervision of Limited Licensed Practitioners . . . Advised that a response from MSNJ will be released shortly on the matter of physician supervision of limited licensed practitioners.
(7) *Membership Directory* . . . Voted to continue listing the names of all physicians in the hospital staff section.

NJ Hospital Association . . .
(1) DRG Waiver . . . Received as informative a report concerning the application guidelines on the demonstration waiver which permits Medicare to participate in the DRG program.
Note: Due to increasing hospital rates, the demonstration waiver is revoked and New Jersey must obtain a new waiver or note that hospitals will be paid for Medicare services in accordance with the national prospective payment system beginning January 1, 1985.

Medical Society of New Jersey Student Association . . . Endorsed the resolution submitted by the Student Association to request the Board of Trustees of UMDNJ not to change the nomenclature of UMDNJ component schools.

Council on Public Relations . . .
(1) Patient Education Program—Resolution #15 (1984) . . . Approved the following three recommendations:

(1) That there not be a voluntary assessment of the membership at this time.
(2) That $40,000 be reallocated from various other accounts to public relations for the 1984 to 1985 fiscal year, bringing the public relations account to $160,000.
(3) That a minimum amount of $200,000 to $225,000 be put into the 1985 to 1986 budget for public relations purposes.

(2) MSNJ Public Relations Firm . . . Approved the following recommendation:

That the Medical Society of New Jersey retain the present public relations firm for the current year. Several public relations firms will be interviewed and requested to provide proposals adapted to a future budget of $200,000-$225,000.

Committee on Impaired Physicians . . .
(1) Protocol for the Management of Physicians Alleged To Be Neurologically Impaired or Senile and No Longer Competent Practitioners . . . Approved the following recommendation:

That the Board of Trustees endorse the Protocol for the Management of Physicians Alleged To Be Neurologically Impaired or Senile and No Longer Competent Practitioners.

(2) Protocol for the Management of Physicians Accused of Sexual Misconduct . . . Approved the following recommendation:

That the Board of Trustees endorse the Protocol for the Management of Physicians Accused of Sexual Misconduct.

(3) License Applications Form . . . Approved the following resolution:

That the resolution in support of the position of the New Jersey Psychiatric Association regarding the present New Jersey Medical Application form be endorsed.

(4) **AMA Conference on Impaired Physicians . . .** Approved the following recommendation:

That MSNJ will underwrite, from the Impaired Physicians Program budget, the expenses incurred by Dr. Ivovich, Dr. McBride, and Edward Reading while attending the AMA meeting on the Impaired Physician in September at the Meadowlands Hilton in Secaucus.

Committee on Conservation of Vision . . . Approved the following recommendation concerning the Statewide Eye Screening Coordinating Council:

That the Medical Society of New Jersey endorse the formation of a Statewide Eye Screening Coordinating Council by the New Jersey State Commission for the Blind and Visually Impaired and appoint a representative from the Committee on Conservation of Vision to serve on the Council.

Old Business . . .

(1) Health Care Facilities Planning Act—Certificate of Need . . . Noted that MSNJ's position remains the same concerning the Health Care Facilities Planning Act: MSNJ would support an amendment requiring a certificate of need from all sources on services that have been regionalized via a duly adopted regulation, contingent upon the regionalization regulation automatically expiring after two years unless readopted on the basis of demonstrated need.

(2) Physicians' Assistants . . . Noted that MSNJ is opposed to the concept of licensure of physicians' assistants in New Jersey.

UMDNJ Notes

Stanley S. Bergen, Jr., M.D.

UMDNJ's ability to care for patients and to provide specialized services for some of the more difficult cases of physicians practicing in New Jersey will be enhanced greatly if the $241 million budget for 1985 to 1986 adopted by our Board of Trustees makes it through the long state appropriation process without damaging cuts.

Among budgeted plans for development of clinical specialty programs are $1.6 million for faculty and enhancement of radiation therapy, chemotherapy, and pathology programs at the Cancer Research and Treatment Center on the Newark campus; $4 million for a new cardiac surgery unit at University Hospital in Newark and additional clinical faculty at both UMDNJ-Rutgers Medical School, Piscataway/New Brunswick and UMDNJ-New Jersey Medical School, Newark; and $1 million for expanding the regional trauma centers at Cooper Hospital/University Medical Center, Camden, and University Hospital, Newark.

Hospital revenues would account for most of the $3 million increase planned to improve the neurosurgery program at University Hospital and staff-donated nuclear magnetic resonance (NMR) imaging equipment at University Hospital, expand pulmonary, anesthesiology, and immunology subspecialties at the medical school; and open new educational programs in southern New Jersey.

Our budget proposal is ambitious but responsible, focusing on University-wide priorities that are based on their importance to New Jersey's health care needs and UMDNJ's long-term goals.

In light of the high rate of cancer mortality in New Jersey, there is significant activity by the state's public university of the health sciences to combat this disease through the most effective therapies known, by educating cancer specialists, and in continuing research to find causes and cures. These developments on the cancer front are noteworthy:

- The Newark-based Cancer Research and Treatment Center, part of University Hospital, has opened a "cancer hotline" available to physicians wanting to make direct referrals and to students doing research. The number, (1-201) 456-6666, is served by a Cancer Center employee during business hours and an answering service on nights and weekends.
- The cancer program at University Hospital has received a three-year certificate of approval from the Commission on Cancer of the American College of Physicians. The approval designated the Newark program at the "teaching hospital" level.
- Twelve UMDNJ faculty members were awarded more than $876,000 of the first $1.2 million granted by the state's new Commission on Cancer Research to undertake basic research that will enlarge our knowledge of this disease. The new st program, funded by a five-cent on cigarettes, is providing vital s money for promising laboratory search efforts that may gener added support from other sour One faculty member, Chung S. Ya Ph.D., professor of biochemistry UMDNJ-New Jersey Medical Sch has received a state grant of $80,0 to study the link betwe esophageal cancer and the s ergestic effects of alcohol consur tion and smoking, and has American Cancer Society grant $155,987 to investigate the conn tion between esophageal cancer a riboflavin deficiency.

It is a great pleasure for me to nounce the appointment of Dr. Ri ard C. Reynolds as UMDNJ's f senior vice-president for acade affairs.

We are fortunate to have an in vidual of Dean Reynold's complishment and recognized pertise to provide the administrat leadership on academic progra and policies for the University. In absence, he will assume authority and responsibilities of president of UMDNJ.

Dr. Reynolds, an internist a community health specialist, ca to UMDNJ in 1978 by way of Johns Hopkins University Schoo Medicine and University of Flor School of Medicine.

His leadership of the UMD Rutgers Medical School through complicated and difficult period growth is testament to his lead ship abilities and calm, consider personality; he continues as dea that school.

The first Distinguished Profes title to be awarded by the UMD Board of Trustees has been give R. Walter Schlesinger, M. emeritus professor of microbiol at UMDNJ-Rutgers Medical Sch and a world-renowned virologist. Schlesinger came to UMDNJ in 19 as professor and chairman of the partment of microbiology, served assistant dean of UMDNJ-Rutg Medical School from 1963 to 19 and acting dean in 1970 to 1971. has received a number of outsta ing awards, published extensiv and been active in a variety of sci tific organizations and projects. continues researching the r tionship of influenza to neurologi complications.

MSNJ Auxiliary

Grace Gellman
President

Thank you Auxiliary members for volunteering your time and talents toward the statewide "Eye Health Screening Program" held during the week of September 17, 1984.

A note of appreciation to Mrs. Charles Moloney and her committee for arranging the super workshop on September 24, 1984, in Lawrenceville. The workshop, "Avenues leading to Personal Success," was presented by John J. Moore, Ph.D., of Loyola University, Chicago. It was a rare opportunity for the membership to enhance those qualities of leadership they already demonstrate.

Are you registered to vote? Is your spouse registered to vote? Do not sit this election out. Do it together—vote on November 6, 1984.

We are fortunate to have an Auxiliary member who also is a travel agent. She can write all travel arrangements—airline tickets and hotel accommodations—and has agreed to contribute her share of commission from these arrangements directly to the Medical Student Loan Fund in the name of the respective county. Call Mrs. John Holdcraft (Grace) at (1-609) 848-2788 for further information.

New Members

The Journal of the Medical Society of New Jersey would like to welcome the following new members:

Atlantic County
Wilfredo Carreno, M.D., Linwood
Frederick G. Dalzell, M.D., Northfield
James A. Wilson, M.D., West Orange

Bergen County
Fe S. Arboleda, M.D., Dumont
Deodatta V. Bendre, M.D., Ridgewood
Richard A. D'Amico, M.D., Englewood
Russell A. Ferstandig, M.D., Ridgewood
John D. Frattarola, M.D., Fort Lee
Salvatore Infantino, M.D., Fair Lawn
David N. Levin, M.D., Teaneck
Norma Jean Murray, M.D., Cliffside Park
George A. Remisovsky, M.D., Fort Lee
Steven M. Stoller, M.D., Ridgewood
Bruce N. Terrin, M.D., Hackensack

Burlington County
Ivan T. Krohn, M.D., Moorestown
J. Mark J. Meredith, M.D., Vincentown
Jeffrey B. Morris, M.D., Marlton
Mark A. Tatz, M.D., Mount Laurel

Camden County
Nathan I. Feldman, M.D., Voorhees
Richard M. Goldfarb, M.D., Voorhees
Robert B. Hill, M.D., Camden
Leonard I. Japko, M.D., Camden
George R. Kenner, Jr., M.D., Camden
Sidi Y. Noor, M.D., Voorhees
Michael J. Reichman, M.D., Cherry Hill
Kenneth J. Weiss, M.D., Camden

Cape May County
Wai-Ling Lai, M.D., Cape May Court House

Cumberland County
Robert E. Coifman, M.D., Vineland
Howard Leibowitz, M.D., Vineland
Armando P. Russo, M.D., Vineland
Rajendra M.R. Sharma, M.D., Vineland
Dirk E. Skinner, M.D., Vineland

Essex County
Carol A. Bainbridge, M.D., Bloomfield
Herbert L. Glatt, M.D., Bloomfield
Stanley Klughaupt, M.D., Belleville
Nicholas G. Melillo, M.D., West Orange
Dragan Pecirep, M.D., Newark
Louis J. Petracca, M.D., Bloomfield
Alan J. Sarokhan, M.D., Short Hills
Ajit M. Shah, M.D., Caldwell
Hilda B. Templeton, M.D., West Orange

Gloucester County
Jeffrey T. Gibson, M.D., Woodbury
James C. McMaster, D.O., Woodbury
Laurence A. Primack, M.D., Sewall

Hudson County
Edith E. Andrade, M.D., North Bergen
Angelo DeMarco, M.D., Newark
Stephen P. McCarthy, M.D., Bayonne

Hunterdon County
Jan K. Kniskern, M.D., Flemington

The *Journal* of the Medical Society of New Jersey
announces the reprinting of the

WILLIAM CARLOS WILLIAMS COMMEMORATIVE ISSUE

September, 1983

Honoring the 100th anniversary of the birth of New Jersey's prize-winning poet and physician. Included in this handsomely illustrated, full-color issue will be original articles by persons close to William Carlos Williams, artwork from his social and intellectual circle, and samples of his finest writings.

Copies of this special issue are available by sending $5.00 for each (check or money order) to MSNJ, Two Princess Road, Lawrenceville, NJ 08648.

Please send a copy of the **William Carlos Williams Commemorative Issue** to:

_____

_____

_____

Enclose a $5.00 check or money order for each copy.

Mercer County
Kaniza A. Banglawala, M.D., Lawrenceville
Alexander S. Carney, M.D., Princeton
Prabodhkumar Damani, M.D., Trenton
Charles J.F. McHugh, M.D., Voorhees
John J. Shelmet, M.D., Trenton
Venkateswaraiyer Subramoni, M.D., Hamilton
Eugene U. Thiessen, M.D., Hightstown

Middlesex County
Venis F. Fanous, M.D., South Bound Brook
Geeta R. Ghanekar, M.D., Iselin
Dieter M. Kramsch, M.D., Rahway
Gary H. Levin, M.D., Edison
Soheir Saad El-Dine Ramadan, M.D., Morristown
Luz E. Rodriquez, M.D., Metuchen
Krishnaswami Srinivasan, M.D., Parlin
Craig J. Wiederman, M.D., Woodbridge

Monmouth County
Steven Berkowitz, M.D., Neptune City
Michael Lee Bernstein, M.D., Colts Neck
Steven A. Bohm, M.D., Freehold
Jeffrey M. Chalal, M.D., Marlboro
Paul M. DiLorenzo, M.D., Asbury Park
Anthony Emanuel, M.D., Freehold
Russell A. Gross, M.D., Colts Neck
Shelly L. Ludwig, M.D., Freehold
Norman S. Nolan, M.D., Middletown
Gerald E. Pflum, M.D., Shrewsbury
Diane Rose, M.D., Marlboro
Eric J. Rosenstock, M.D., Neptune
Vardha S. Sailam, M.D., Red Bank
Joseph W. Schauer, M.D., III, Farmingdale
Rajagopalan Sivaprasad, M.D., Long Branch

Morris County
Eugenia George, M.D., Maplewood
Richard R. Hawrylo, M.D., Morristown
Chong S. Jaw, M.D., Parsippany
Stephen D. Krasnica, M.D., Denville
Bertram Kummel, M.D., Morristown
Barbara Mitchell, M.D., Morristown
Robert F. Mohr, M.D., Morristown
James B. Rubenstein, M.D., Morristown

Ocean County
Bankim Shah, M.D., Whiting

Passaic County
John J. Farkas, M.D., Paterson
Rita B. Jhaveri, M.D., Paterson
Thil Yoganathan, M.D., Paterson

Somerset County
Robert A. Harman, M.D., Somerville
Angela Lanfranchi, M.D., Bound Brook
Simon D. Murray, M.D., Somerset

Union County
Shalom Y. Abboudi, M.D., North Plainfield
Kenneth M. Bahrt, M.D., Plainfield
Walter J. Borowski, M.D., Linden
John N. Burling, M.D., Linden
Joseph P. Calderone, Jr., M.D., Mountainside
Thomas J. Gianis, M.D., Summit
James Scott Gillin, M.D., Summit
Alan W. Goldfeder, M.D., Union
Joseph Guida, M.D., Linden
Alan H. Greenspan, M.D., Westfield
Anthony Iuzzolino, M.D., Hillside
Sabata J. Lombardo, M.D., Elizabeth
Uday C. Mehta, M.D., Mountainside
Bernard M. Wagner, M.D., Summit

Tamisiea Award

At the annual meeting of the Aerospace Medical Association, May 6 to 11, 1984, in San Diego, California, Dr. Milton H. Gordon was the recipient of the John A. Tamisiea Award given annually to an individual who has made an outstanding contribution to the art and science of aviation medicine in its application to general aviation.

Dr. Gordon, a fellow of the Association, moved to Israel with his wife, Natalie, in 1974. Since that time he has been serving as the civil air surgeon of the state of Israel, the chief medical officer for civil aviation medicine. In that capacity his special field of interest has been agricultural aviation and toxicology in its relation to the health and safety of spray pilots and ground crews, and it is for this particular area of aviation medicine that he has been especially recognized.

The Aerospace Medical Association is the world's largest society of its kind with 4000 members consisting of physicians, engineers, physicists, physiologists, and air crew members.

Dr. Gordon is a member of the Medical Society of New Jersey.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ALLERGY/IMMUNOLOGY—Leonard Bielory, M.D., 688 Concerto La., Silver Spring, MD 20901. UMDNJ 1980. Board eligible. Solo preferred, but flexible. Available March 1985.

T.M. Bokhari, M.D., 48 Anderson Pkwy., Cedar Grove, NJ 07009. FJMC. Also infectious diseases (pediatric). Board certified (PED). Group, partnership, solo. Available.

ANESTHESIOLOGY—Cau Pham, M.D., 856 Nelson, Apt. 206, Chicago, IL 60657. Saigon (South Vietnam) 1974. Group or partnership. Available.

FAMILY MEDICINE—Mary F. Campagnolo, M.D., 10 Overlook Rd., Apt. 5-E, Summit, NJ 07901. George Wa- ington University 1982. Board eligi- Group or partnership. Available J- 1985.

GASTROENTEROLOGY—Harry Burack, M.D., 5548 Waterman Pl., Louis, MO 63112. Albany 1978. A- internal medicine. Board certifi- Partnership, group, solo. Available.

Prakash V. Huded, M.D., 80-15 41 A- Apt. 606, Elmhurst, NY 113- Karnatak (India) 1970. Board certifi- Solo, group, partnership. Available.

Neil Tarkin, M.D., 6700 192nd Fresh Meadows, NY 11365. New Y- Medical 1978. Also, internal medici- Board certified (IM). Any type pract- Available.

GENERAL MEDICINE—John J. K- M.D., 127 Garfield Ave., Jersey City, 07305. Catholic Medical Coll- (Korea) 1966. Group, partnership, s- Available.

INTERNAL MEDICINE—David M. Br- bart, M.D., 50 Hillpark Ave., Apt. 1- Great Neck, NY 11021. SUNY-Do- state 1979. Also pulmonary medici- Board certified (IM); board eligi- (PM). Pulmonary, pulmonary/inter- medicine, multispecialty group. Av- able July 1985.

Harry D. Burack, M.D., 5548 Waterm- Pl., St. Louis, MO 63112. Albany 19- Also gastroenterology. Board certif- Partnership, group, solo. Available.

Aditi Gupta, M.D., 27 Sturbridge West, Piscataway, NJ 08854. L- Hardinge (India) 1980. Board eligi- Clinic/hospital or group. Available

Lee W. Hoffer, M.D., 1017 E. 80th Brooklyn, NY 11236. Rome (Italy) 19- Solo, partnership, group. Available

Quang T. Nguyen, M.D., 15 Englewood Ave., Bergenfield, NJ 076- Saigon (South Vietnam) 19- Subspecialty, nephrology. Bo- eligible. Any type practice. Availab-

Claudia Anne Pollet, M.D., 6- Parkway Dr., Baltimore, MD 212- Mount Sinai 1981. Board eligi- Salaried position in emergency ro- clinic, or urgent care center. Availa-

Paul V. Renda, M.D., 3206 Myra Apt. D, Durham, NC 27707. Mo- Sinai 1981. Board eligible. Solo, gro- clinic (preferably southern NJ). Av- able.

Virod K. Shah, M.D., 345 Watkins La- Battle Creek, MI 49017. M.P. Sh- (India) 1975. Board eligible. Any t- practice. Available.

Neil Tarkin, M.D., 6700 192nd Fresh Meadows, NY 11365. New Y- Medical 1978. Also, internal medici- Board certified (IM). Any type pract- Available.

Robert L. Werner, D.O., 148 Reser- Rd., Parsippany, NJ 07054. UMD- NJSOM 1981. Board eligible. Solo partnership. Available July 1985.

NEPHROLOGY—Quang T. Nguyen, M- 15 W. Englewood Ave., Bergenfield, J-

07621. Saigon (South Vietnam) 1967. Also, internal medicine. Board eligible. Any type practice. Available.

OBSTETRICS/GYNECOLOGY—Edwin R. Guzman, M.D., 1200 E. 98th St., Brooklyn, NY 11236. New York Medical 1980. Board eligible. Group or partnership. Available.

Atul S. Sheth, M.D., 2951 S. King Dr., Chicago, IL 60616. T.N. Medical College (India) 1972. Specializing in infertility, reproductive endocrinology. Board eligible. Partnership, single multiple group practice, academia. Available.

OCCUPATIONAL MEDICINE—Errol Emmet Vernon, M.D., 2018 Pickerton Dr., Deer Park, TX 77536. University of the West Indies (Jamaica) 1978. Board eligible. Group. Available.

PATHOLOGY—Steven P. Katz, M.D., 9634 S. Karlov Ave., Oak Lawn, IL 60453. Nebraska 1972. Board certified (PA and CLIN). Hospital or group. Available on one month's notice.

PEDIATRICS—Charles H. Geneslaw, M.D., 8372 Loveridge Ct., Richmond, VA 23229. UMDNJ 1982. Partnership. Available July 1985.

PULMONARY MEDICINE—David M. Breidbart, M.D., 50 Hillpark Ave., Apt. 1-R, Great Neck, NY 11021. SUNY-Downstate. Also, internal medicine. Board eligible (PM); board certified (IM). Pulmonary, pulmonary/internal medicine, multispecialty group. Available July 1985.

SURGERY, GENERAL—Leonardo A. Garduno, M.D., 2170 S. Goebbert Rd., Apt. 1-109, Arlington Heights, IL 60005. University of the East (Philippines) 1968. Any type practice. Available.

Daniel M. Goldman, M.D., 3450 Wayne Ave., Apt. 19-S, Bronx, NY 10467. Also, vascular surgery. Board eligible. Partnership or single specialty group. Available July 1985.

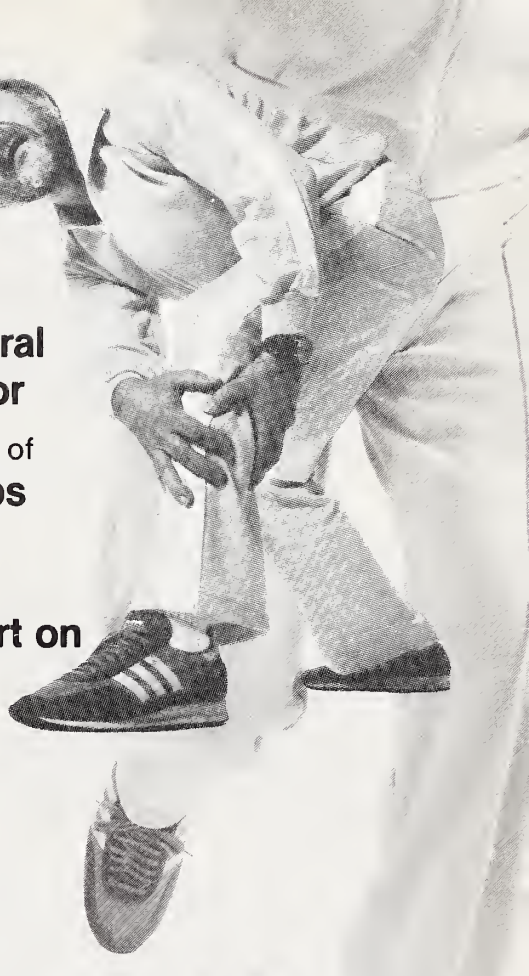
David A. Guthrie, M.D., 3130 Heathstead Pl., Charlotte, NC 28210. West Virginia 1978. Also, vascular surgery. Board eligible. Group or partnership. Available July 1985.

Barry Jordan, M.D., 260 Garth Rd., Scarsdale, NY 10583. South Carolina 1977. Board eligible. Group, partnership, solo. Available.

J. Bernard LeSage, M.D., P.O. Box 699, Middlesboro, KY 40965. Montreal (Canada) 1945. Board certified. Administrative medicine. Available.

SURGERY, VASCULAR—Daniel M. Goldman, M.D., 3450 Wayne Ave., Apt. 19-S, Bronx, NY 10467. Also, general surgery. Board eligible. Partnership or single specialty group. Available July 1985.

David A. Guthrie, M.D., 3130 Heathstead Pl., Charlotte, NC 28210. West Virginia 1978. Also, general surgery. Board eligible. Group or partnership. Available July 1985.



A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release
LIPO-NICIN®/300 mg.

Each time-release capsule contains:
Nicotinic Acid .....300 mg.
Ascorbic Acid.....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2).....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release
LIPO-NICIN®/250 mg.

Each yellow tablet contains:
Nicotinic Acid .....250 mg.
Niacinamide.....75 mg.
Ascorbic Acid.....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2).....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide.....75 mg.
Ascorbic Acid.....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2).....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

THE ACADEMY OF MEDICINE
OF NEW JERSEY

presents

a symposium on

HYPERTHERMIA FOR CANCER

Saturday, October 13, 1984
8:30 a.m.-3:00 p.m.

at

MSNJ HEADQUARTERS, Lawrenceville, N.J.

This Symposium will present the most current scientific information concerning the concomitant use of Hyperthermia in the treatment of cancer of the body, including the brain.

PROGRAM CHAIRMAN:
Arthur Winter, M.D.
Attending Neurological Surgery
The Hospital Center at Orange
Saint Barnabas Medical Center,
Livingston

For further information, please contact:



EXECUTIVE OFFICES
The Academy of Medicine of New Jersey
Two Princess Road
Lawrenceville, NJ 08648
(609) 896-1717

The Academy of Medicine of New Jersey
Physicians for Social Responsibility,
Northern New Jersey Chapter
Department of Preventive Medicine and Community Health
UMDNJ—New Jersey Medical School

present
a symposium on

POTENTIAL HUMAN AND ECOLOGIC DISASTERS

Saturday, October 20, 1984
9:00 a.m.-3:00 p.m.

at

Town & Campus Restaurant
West Orange, New Jersey

Those who attend this conference will gain an understanding of th following:

The consequences of exposure to high level radiation with a particu lar emphasis on long term effects on birth defect and tumor incident

The consequences of exposure to low level radiation (radium ar uranium). Mechanism of exposure and health risk will be discusse

The health effects of exposure to leakage from chemical toxic was disposal sites and all the available studies that have been complete will be reviewed and the requirements for additional study will b analyzed.

For further information, please contact:



EXECUTIVE OFFICES
The Academy of Medicine of New Jers
Two Princess Road
Lawrenceville, NJ 08648
(609) 896-1717



LIKOFF CARDIOVASCULAR INSTITUTE

of Hahnemann Medical College & Hospital

230 N. Broad Street, Philadelphia, Pennsylvania 19102 (215) 448-8063

CARDIOLOGY UPDATE. . .

IS DESIGNED FOR THE PHYSICIAN AND PROVIDES AN INTENSIVE SURVEY OF THE CURRENT STATUS OF CLINICAL CARDIOLOGY. . .

WEDNESDAY, NOVEMBER 7, 1984

SUDDEN DEATH

MODERATOR: JOEL MORGANROTH, M.D.

3:00 CASE PRESENTATION — *Pasquale M. Procacci, M.D.*
3:30 THE ROLE OF ELECTROPHYSIOLOGIC STUDIES IN THE MANAGEMENT OF PATIENTS WITH VENTRIBULAR ARRHYTHMIAS — *Charles R. Webb, M.D.*
4:00 IDENTIFICATION OF PATIENTS AT HIGH RISK TO SUDDEN DEATH — *Scott R. Spielman, M.D.*
4:30 CAN WE SELECT DRUGS BASED ON ELECTROPHYSIOLOGIC MECHANISMS AND PHARMACOLOGIC PRINCIPLES? — *Leonard N. Horowitz, M.D.*
5:00 NEW ANTIARRHYTHMIC AGENTS: USE AND LIMITATIONS OF ENCAINIDE, FLECANIDE, AMIODARONE, ETHMOZIN AND MEXILITINE — *Joel Morganroth, M.D.*

LECTURE HALL "A"—2nd floor New College Building, Hahnemann University
15th and Vine Streets, Philadelphia, PA

• NO REGISTRATION FEE • NO ADVANCE REGISTRATION REQUIRED •
• CME CATEGORY I CREDITS CERTIFIED •
WINE & CHEESE SERVED FOLLOWING CONFERENCE

CME CALENDAR

The following is a list of continuing medical education courses for the next two months. Contact the sponsoring organization for further information.

This list is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the UMDNJ. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

Nov.

20 **Dinner Meeting**
6-9 P.M.—Ramada Inn, Clark
(NJ State Society of Anesthesiologists and AMNJ)

CARDIOLOGY

Nov.

7 **Modern Concepts in Echocardiography**
9:30-11 A.M.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)

15 **Cardiology: Newer Cardiac Drugs**
2-3 P.M.—John E. Runnells Hospital of Union County
(John E. Runnells Hospital and AMNJ)

Dec.

18 **Streptokinase and Percutaneous Transluminar Angioplasty**
12 noon—St. Mary's Hospital, Orange
(AMNJ)

MEDICINE

Nov.

1 **Antibiotic Updates**
9 A.M.—Freehold Area Hospital
(AMNJ)

1, 8, 15, 29 **Immunoregulation: Basic Concepts and Applications**
4-6 P.M.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

2 **AIDS**
12 noon-1 P.M.—Freehold Area Hospital
(AMNJ)

2 **ND-YAC Laser in G.I.**

16 **The Physician as a Patient**

30 **Sanity in Today's Beta-Blocker Market**
9 A.M.—Crean Hall, St. Francis Medical Center, Trenton
(St. Francis Medical Center)

6 **Antibiotic Update**
9-10 A.M.—Freehold Area Hospital
(AMNJ)

7 **AIDS**
1-2:30 P.M.—Christ Hospital, Jersey City
(AMNJ)

7 **Indications for Invasive Studies**
12 noon—St. Mary's Hospital, Passaic
(AMNJ)

7, 14, 21, 28 **Medical Grand Rounds**
12 noon-1 P.M.—Rutgers Medical School, Medical Education Bldg., New Brunswick
(UMDNJ and AMNJ)

7 **Medicine Morbidity and Mortality Conference**
8-9 A.M.—Rutgers Medical School, Medical Education Bldg., New Brunswick
(UMDNJ and AMNJ)

7 **Common Dermatoses**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)

7, 14, 21, 28 **Endocrine Conferences**
3:30-5 P.M.—Rotates between Newark Beth Israel Medical Center, University Hospital, United Hospitals Medical Center, Newark, and VA Medical Center, East Orange
(Endocrinology Section, AMNJ)

12 **A New Medical Entity—Mixed Angina**
7-8:30 P.M.—Wallkill Valley General Hospital
(Pfizer Laboratories and AMNJ)

13 **Topic To Be Announced**
8-10 P.M.—Schering Corp., Kenilworth
(NJ Dermatological Society and AMNJ)

14 **Early Diagnosis and Treatment of Commonly Seen Office Problems**
8:30 A.M.-5 P.M.—Medical Society of NJ, Lawrenceville
(NJ Academy of Family Physicians and AMNJ)

14 **Dermatologic Manifestations of Life-Threatening Illness**
1-2:30 P.M.—Bldg. 93, VA Medical Center, Lyons
(VA Medical Center and AMNJ)

15 **Diagnosis and Management of Anaerobic Infection**
5-7:30 P.M.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

15 **Case Presentations**
8-10 P.M.—The Mountainside Hospital, Montclair
(NJ Gastroenterological Society and AMNJ)

20 **New Treatment Modes and Implications for the Future in Diabetes**
12 noon—St. Mary's Hospital, Orange
(St. Mary's Hospital and AMNJ)

21 **Dermatological Conferences**
6-9 P.M.—Rutgers Community Health Plan, U.S. Hwy. 1 & Rt. 18, New Brunswick
(UMDNJ and AMNJ)

21 **Mitral Valve Prolapse**
1-2 P.M.—West Hudson Hospital, Kearny
(West Hudson Hospital and AMNJ)

21 **Antiviral Update**

28 **Modern Concepts and Etiology of Diabetes Mellitus**
9:30-11 A.M.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)

28 **Dermatologic Manifestations of Life-Threatening Illness**
1-2:30 P.M.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

28 **Controversies in Geriatrics**
1-5 P.M.—Medical Society of NJ, Lawrenceville
(AMNJ)

29 **Laser Treatment of Massive GI Hemorrhage**
11 A.M.-12 noon—St. Joseph's Hospital and Medical Center, Paterson
(AMNJ)

Dec.

4 **AIDS**
9:00 A.M.—Holy Name Hospital, Teaneck
(AMNJ)

5 **AIDS**
9:00 A.M.—Warren Hospital, Phillipsburg
(AMNJ)

5 **Clinical Abstract Meeting**
1-5 P.M.—The Manor, West Orange
(Oncology Society of NJ and AMNJ)

5, 12, 19, 26 **Endocrine Conferences**
3:30-5 P.M.—Rotates between Newark Beth Israel Medical Center, University Hospital, United Hospitals Medical Center, Newark, and VA Medical Center, East Orange
(Endocrinology Section and AMNJ)

5, 12 **Medical Grand Rounds**
12 noon-1 P.M.—Rutgers Medical

Temple University Hospital

Department of Orthopedic Surgery is pleased to announce the association of Russell E. Windsor, MD within the practice of orthopedic surgery including joint reconstruction and sports medicine.

THE MEDICAL SOCIETY OF NEW JERSEY

PRESENTS

WOMEN PHYSICIANS LEADERSHIP CONFERENCE

SATURDAY, OCTOBER 27, 1984
8:30 AM-3:00 PM

MEDICAL EDUCATION BUILDING
UMDNJ-RUTGERS
NEW BRUNSWICK, NEW JERSEY

LUNCH & RECEPTION

STUDENTS	RESIDENTS	PHYSICIANS
$5.00	$10.00	$25.00

Reservations—1-609-896-1766

1985 CME CRUISE/CONFERENCES ON SELECTED MEDICAL TOPICS

Caribbean, Mexican, Hawaiian, Alaskan, Mediterranean. 7-14 days year-round. Approved for 20-24 CME Cat. 1 credits (AMA/PRA) & AAFP prescribed credit. Distinguished professors. FLY ROUNDTRIP FREE ON CARIBBEAN, MEXICAN, & ALASKAN CRUISES. Execellent group fares on finest ships. Registration limited. Pre-scheduled in compliance with present IRS requirements.

Information: International Conferences, 189 Lodge Ave., Huntington Station, N.Y. 11746. (516) 549-0869.

ARE YOU A SAINT MICHAEL'S ALUMNUS

Saint Michael's Medical Center, Newark, NJ, a 117 year old teaching hospital, is forming a medical alumni association. We are seeking some 5,000 physicians who served as residents and interns. Over the years many of our former house staff members have relocated making consistant communication difficult.

Our alumni association will be oriented towards four goals: professional, medical, social and educational. Plans are already being made for a medical reunion dinner and symposium in the fall.

If you are a former member of Saint Michael's house staff or know another staffer's whereabouts, please call (201) 877-5494 or write to:

SAINT MICHAEL'S MEDICAL CENTER
268 Dr. Martin Luther King, Jr. Blvd.
Newark, NJ 07102
attn: Office of Public Affairs

POST-GRADUATE NYU Medical Center MEDICAL SCHOOL

WINTER COURSE SCHEDULE

DECEMBER

12/3-6	350. Neurosurgery NYC/1984 (Grand Hyatt)
12/3-7	314. Toxicology and Pharmacology
12/10-12	321 Managing Clinical Problems in the Elderly
12/17-22	603 Computed Tomography (Grand Hyatt)
12/15-16	733 Basic Review of Pathology and Radiology for Urologists

JANUARY

1/9-6/26/85	302. Internal Medicine Board Review Wednesdays 4:00 to 7:00pm

MARCH

3/11-15	321b Managing Clinical Problems in the Elderly (Cerromar Beach Hotel, Puerto Rico)
3/11-15	603b. Computed Tomography (Cerromar Beach Hotel)
3/18-22	304 Seminar in Advanced Rheumatology
3/25-29	100. Anesthesiology Board Review IV
3/30-31	735. Lasers in Urology

FOR INFORMATION

NYU Post-Graduate Medical School
550 First Avenue New York, NY 10016
(212) 340-5295 (24hr. service)

NEW YORK FERTILITY RESEARCH FOUNDATION, INC.

For the Investigation of
Problems of Human Infertility

The Foundation provides a complet diagnostic and consultation service for in fertile couples. Investigations are con ducted by well-known specialists in con junction with consultants in the variou fields of medicine related to infertility.

The Foundation is supported by an in house modern laboratory equipped to d most tests required for diagnosis an treatment. Literature on request.

1430 Second Avenue, Suite 103
New York, N.Y. 10021
Phone: (212) 744-5500

9 School, Medical Education Bldg., New Brunswick
(UMDNJ and AMNJ)

6 **Management of Congenital Infections**
9 A.M.—Freehold Area Hospital
(AMNJ)

6 **Immunoregulation: Basic**
3 **Concepts and Applications**
4-6 P.M.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

7 **Medicine Morbidity and Mortality Conference**
8-9 A.M.—Rutgers Medical School, Medical Education Bldg., New Brunswick
(UMDNJ and AMNJ)

2 **Clinical Immunology**
1:00 P.M.—VA Medical Center, Lyons
(AMNJ)

2 **What Is New in Allergy?**
8-9:30 P.M.—Schering Corporation, Kenilworth
(NJ Allergy Society, Schering Corp., and AMNJ)

13 **Management of Abdominal Emergencies**
11:00 A.M.—St. Joseph's Hospital and Medical Center, Paterson
(AMNJ)

13 **The Prevention and Reversibility of Heart Disease**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

13 **Indications, Techniques, and Results in Coronary Thrombolysis**
5-7:30 P.M.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

NEUROLOGY/PSYCHIATRY

Nov.

1 **Psychotherapy Outcome Research**
8 **The Wish To Be Held**
15 **Smoking, Personality, and Health**
29 **Humor In Psychotherapy**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

2 **Lecture Series**
9 1:30-5:30 P.M.—Trenton
16 Psychiatric Hospital
23 *(NJ Division of Mental Health and*
30 *Hospitals and AMNJ)*

3 **Clinical Issues in Adoption**
8:30 A.M.-5 P.M.—Fair Oaks Hospital, Summit
(Fair Oaks Hospital and AMNJ)

5 **Psychosomatic Disorder Followed by a Tic**
8:15-10:30 P.M.—192 Chittenden Road, Clifton
(Essex Psychiatric Seminar and AMNJ)

7 **Therapeutic Touch—Research and Clinical Findings**
1-2:30 P.M.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)

7 **Louis Loeser Memorial Lecture**
8-10 P.M.—South Mountain School, South Orange
(NJ Psychiatric Association, NJ Medical School, and AMNJ)

8 **Certain Aspects of Forensic Psychiatry Applicable to the Chronic Care Psychiatric Hospital**
1-3 P.M.—Essex County Hospital Center, Cedar Grove
(Essex County Hospital and AMNJ)

10 **Prevention of Mental Illness in Children**
9 A.M.-4 P.M.—The Mountainside Hospital, Montclair
(The Mountainside Hospital and AMNJ)

14 **Industrial/Occupational Medicine and Psychiatry**
9:15 A.M.-4:30 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

15 **Topic To Be Announced**
8:30 P.M.—Hackensack Medical Center
(NJ Psychoanalytic Society and AMNJ)

15 **Psychopharmacology I**
29 **Psychopharmacology II**
3-4 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

17 **What's New in the Management of Cerebrovascular Disease?**
8 A.M.-4 P.M.—Marriott, Saddle Brook
(UMDNJ-NJ Medical School and AMNJ)

19 **Lecture Series**
8:30-10:30 P.M.—301 Broad Ave., Englewood
(NJ Psychoanalytic Society and AMNJ)

Dec.

3 **Survival Guilt with Somatic Symptoms**
8:15-10:30 P.M.—4 Garden Place, Nutley
(Essex Psychiatric Seminar and AMNJ)

3 **When the Patient Abuses Drugs: Skills for the Outpatient Therapist**
1-4 P.M.—Fair Oaks Hospital, Summit
(Fair Oaks Hospital and AMNJ)

6 **Medical Hypnosis Course**

***The Journal* of the Medical Society of New Jersey**

presents

300 YEARS OF MEDICINE IN NEW JERSEY

September 1984

We are celebrating the history of medicine in New Jersey. This special issue illuminates the beginnings of our health care system and the growth of medical care: essays highlight those talented individuals who devoted themselves to this system, and commentaries present the development of specialized care in associated fields of medicine. Plus a special photography section highlighting three statewide exhibits.

Copies of this issue are available by sending $5.00 (check or money order) to MSNJ, Two Princess Road, Lawrenceville, NJ 08648. All MSNJ members will receive one copy of this issue.

Name _____

Address _____

_____

Enclose a $5.00 check or money order for each copy.

13 4-8 P.M.—Carrier Foundation, Belle Meade
(Carrier Foundation and AMNJ)

12 **Sleep Disorders**
1:30-2:30 P.M.—Rutgers Community Health Plan, 57 U.S. Hwy. #1, New Brunswick
(Rutgers Community Health Plan and AMNJ)

13 **Becoming a Psychotherapist**
12 noon-1 P.M.—Carrier Foundation, Belle Meade
(Carrier Foundation and AMNJ)

13 **Child Sexual Abuse**
8:30 A.M.-5 P.M.—Fair Oaks Hospital, Summit
(Fair Oaks Hospital and AMNJ)

20 **Coordination of Psychiatric Treatment in the Hospital and Community**
3:00 P.M.—Ancora Psychiatric Hospital, Hammonton
(Ancora Psychiatric Hospital)

17 **Lecture Series**
8:30-10:30 P.M.—301 Broad Ave., Englewood
(NJ Psychoanalytic Society and AMNJ)

OBSTETRICS/GYNECOLOGY

Dec.

3 **Prophylactic Mastectomy and Treatment of the Second Breast**
8 A.M.-5 P.M.—UMDNJ-Rutgers Medical School, Medical Education Bldg., New Brunswick
(UMDNJ-Rutgers Medical School)

4 **Psychosocial Issues and Interactions in Breast Disease**
9 A.M.-4 P.M.—UMDNJ-Rutgers Medical School, Medical Education Bldg., New Brunswick
(UMDNJ-Rutgers Medical School)

PATHOLOGY

Nov.

17 **Surgical Pathology of the Breast: Diagnosis and Therapeutic Implications**
9 A.M.-1 P.M.—Rutgers Medical School, Piscataway
(NJ Society of Pathologists and AMNJ)

PEDIATRICS

Nov.

6 **Newer Aspects of Pneumonia in Infants and Children**
8:30-9:30 A.M.—Newark Beth Israel Medical Center
(Newark Beth Israel Medical Center and AMNJ)

7 **Current Diagnosis and Management of Pediatric Rheumatologic Diseases**
8:30 A.M.-2 P.M.—Rutgers Medical School, Piscataway
(Arthritis Foundation, NJ Chapter, NJ Rheumatism Association, and AMNJ)

9 **The Current Approach to the Investigation and Management of Urinary Tract Infections in Children**
8-9:30 A.M.—Overlook Hospital, Summit
(Overlook Hospital and AMNJ)

RADIOLOGY

Nov.

7 **Newer X-ray Imaging Techniques**

21 1:30-2:30 P.M.—Rutgers Community Health Plan, 57 U.S. Hwy. #1, New Brunswick
(Rutgers Community Health Plan and AMNJ)

8 **Current Status of Carotid Imaging**
7:30 P.M.—Saint Barnabas Medical Center, Livingston
(NJ Institute of Ultrasound in Medicine, Radiological Society of NJ, and AMNJ)

20 **Nuclear Magnetic Resonance**
12 noon—St. Mary's Hospital, Orange
(AMNJ)

21 **Radiation Therapy Oncology Group**
6:30-9:30 P.M.—The Manor, West Orange
(Radiotherapy Section, AMNJ)

Dec.

5 **NMR—Clinical Imaging**
1:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)

15 **Topic To Be Announced**
7:30-10 P.M.—Saint Barnabas Medical Center, Livingston
(NJ Institute of Ultrasound in Medicine and AMNJ)

20 **Radiology Meeting**
7:30 P.M.—Saint Barnabas Medical Center, Livingston
(Radiological Society of NJ and AMNJ)

SURGERY

Dec.

1 **Clinical Meeting**
All Day Session—UMDNJ-NJ Medical School, Newark
(NJ Chapter, American College Surgeons and AMNJ)

6 **Surgical Treatment of Morbid Obesity**
12 noon—West Jersey Hospital, Camden
(AMNJ)

14 **Surgical Emergencies in the Newborn**
8-9:30 A.M.—Overlook Hospital, Summit
(Overlook Hospital and AMNJ)

18 **Arterial Clot Lysis Using Streptokinase**
8-10 P.M.—Englewood Club, Englewood
(Englewood Surgical Society ar AMNJ)

SURGICAL SPECIALTIES

Nov.

27 **Breast Reconstruction After Mastectomy**
8-10 P.M.—Englewood Club, Englewood
(Englewood Surgical Society ar AMNJ)

MISCELLANEOUS

Nov.

1 **Medical Hypnosis Course**

8 4-8 P.M.—Carrier Foundation, Be

15 Meade

29 *(Carrier Foundation and AMNJ)*

14 **Withholding or Withdrawal of Li Support—Legal and Ethical/Moral Aspects**
8:30 A.M.-3:30 P.M.—Hilton Inn, Tinton Falls
(NJ Society of Critical Care Medicine and AMNJ)

Dec.

5 **DRG—Cost Containment**
10:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

29 **Nuclear Holocaust Prevention**
12 noon-1 P.M.—Carrier Foundation, Belle Meade
(Carrier Foundation and AMNJ)

Dr. Martland's Ashes;
Dr. Leon J. Anson

Dr. Martland's Ashes

July 5, 1984

Dear Doctor Krosnick:

Your response to Dr. James Bellet's letter to the Editor (April 1984) in which he criticized you for using a photograph of Dr. Harrison S. Martland on *The Journal* cover, a cigarette between his lips while performing an autopsy, was cogent to the extent that it was based on the historical perspective of smoking.

Unanswered, however, was Dr. Bellet's comment on Dr. Martland's insensitivity of the ashes dangling and about to fall on the remains of the cadaver." Like many others, he felt better able to concentrate on the matter at hand with a cigarette between his lips even without puffing. More to the point, ashes never fell on a cadaver; one of the interns near him (and they always were crowded around the table) would hold a sheet of paper under the cigarette and tap it to dislodge the ashes at the appropriate time. Martland's assistant held a small hose and washed blood from the organ whenever it was advanced toward him, which was frequently; always respect, always cleanliness.

If the individual on the table being studied could have noted the intensity of Martland's search for the truth and the intensity of the intern's attention to his remarks, the cigarette would have been forgiven. I am sure that Dr. Bellet would have tolerated the cigarette if he had had the good fortune of attending one of Dr. Martland's renowned autopsy performances.

(signed) Samuel Berg, M.D.

Dr. Leon J. Anson

July 20, 1984

Dear Doctor Krosnick:

When we lose a revered colleague, it does not seem enough for *The Journal* to announce on the obituary page just the bare facts of his or her career. I enclose such a fact sheet for publication, but I feel it more fitting that the information be conveyed in the following way:

On June 21, 1984, Leon J. Anson, M.D., died, after 44 years of dedicated and compassionate service to his Union County patients. Born in New York City on February 5, 1913, Dr. Anson graduated from the Medical College of Virginia in 1938. After further training at Conemaugh Valley Memorial Hospital, Johnstown, PA, and Newcomb Memorial Hospital, Vineland, he entered private practice in Fanwood in 1939. He continued there until 1978, except for 2 years during the Second World War when he served as a captain in the Air Force. He was affiliated with Overlook Hospital, where the Family Practice Service remains as a living tribute to him; he initially was associated with its development, and remained the zealous custodian of its growth and direction, and drafted the original bylaws for the department.

Dr. Anson was a Renaissance man—he practiced modern medicine expertly, but in an old-world way. Always available to his patients (he never took vacations), whether their need was for medical treatment, or help in a family crisis; he knew all the members of each household, as he cared for three and even four generations of them.

Dr. Anson was a serious student of Shakespeare, with a great love for the sonnets. He also was a Wagnerite, who could amuse his opera buff friends by singing along with Callas, as well as Melchior. His expert knowledge and fine collection of oriental rugs added to the luxury of sharing musical sessions in his home. As with his medicine, he continued to read and add to his knowledge and understanding of these interests to the end of his days.

His effectiveness in organizing physician colleagues in the hospital, the Medical Society of New Jersey, and the Summit Medical Society in large measure was due to the energy and integrity with which he set about each task, but his wry humor and instinct for bringing people together, were the means by which he crafted an extended family throughout the hospital.

He is survived by his wife, Betty Bowers Anson; a daughter, Judith Anson Lee; and four grandchildren, Tadd, Maya, Joshua, and Jared Lee, of Vista, California; also a sister, Doris Krumholz of New York City.

I trust you will find room for some of this more alive portrait of Leon and perhaps in the future *The Journal* will encourage the submission of tributes, instead of bare facts.

(signed) Margaret E. Symonds, M.D.

Alzheimer's Disease; Current Pediatric Diagnosis and Treatment; Illustrated Textbook of Gynaecology; Law of Medical Practice in Pennsylvania and New Jersey; Review of Medical Microbiology

Alzheimer's Disease: The Standard Reference

Barry Reisberg, M.D., (ed). New York, NY, The Free Press (Macmillan Division), 1983. Pp. 475. Illustrated.

Barry Reisberg, M.D., assistant professor, department of psychiatry, New York University Medical Center, has composed a textbook and brought together all of the research and information on the clinical and pathological aspects of Alzheimer's disease (AD). World-renowned experts have written and covered the history, background of AD, pathology, neurochemistry, epidemiology, and genetic aspects; the clinical, differential, and psychometric diagnoses, as well as diagnostic procedures and therapeutic treatments are likewise discussed.

By presenting this volume of the most recent research, he hopes he has laid the groundwork for future research.

AD is the fourth leading cause of death in the United States and the major cause for nursing home admissions among Americans. In its mild to moderate stages, it results in early retirement and social withdrawal for millions of people throughout the world. The incidence of AD continues to grow as the disease of the century. Thousands also are confined in state and veterans hospitals, and a majority of persons are cared for in their own homes by relatives and home health aides, requiring continuous supervision and care.

This neuropathological entity was described clearly by Alois Alzheimer in 1907. Interestingly, it was described by Sophocles in the 5th century, B.C., and reinforced by Shakespeare in his description of the behavior patterns of King Lear. Often terms such as "senile dementia," or "presenile dementia," or "primary degenerative dementia" are used clinically to describe cognitive abnormalities, not invariably associated with AD type brain damage. Many theories as to cause still are being followed in research laboratories around the world.

The purpose of this volume is to establish a milestone for the medical profession's understanding of AD. One fact is made clear in many of the discussions: AD is not a normal characteristic of aging. It may be that AD, like hypertension and atherosclerosis, is a multifactorial disease, and if this is true, then the medications that are suitable for the management of the symptoms have yet to be found. However, one medication does stand out, the ergoloid mesylates. It is the most widely used and investigated cerebral metabolic enhancing agent. It has been postulated by Reisberg that ergoloid mesylates may be more effective in senile dementia of AD than in those with multi-infarct dementia.

In comparison with placebo, or with papaverine, the ergoloid mesylates have shown a good margin of safety in elderly patients and somewhat superior results.

Alzheimer's Disease is indeed well recommended for all clinicians, students, and health science libraries.

Harry M. Poppick, M.D.

Current Pediatric Diagnosis and Treatmen 8th Edition

C. Henry Kempe, M.D., Henry K. Silver, M.D., and Donough O'Brien M.D., (eds). Los Altos, CA, Lange Medical Publications, 1984. Pp 1164. ($27)

Dr. Kempe died recently. The world pediatric community will miss him. He will be remembered fo many contributions including alerting us to the problems of child abuse and for his shepherding this marvelous text through eight wonderful editions.

I have been practicing pediatrics for 30 years. Nonetheless, this tex provided some new, useful, o interesting fact every ten pages. It is a good book to keep on your desk fo use when puzzling problems arise o to peruse during quiet moments, assuming that taking care of childre ever allows quiet moments.

The present federal adminis tration is not likely to be pleased with the chart on page 671 which suggests that early surgical intervention is not recommended for a newborn if severe cerebral birth trauma and gross disabling congenital abnormalities are present. On the other hand they might like the suggestion on page 324 that $200,000,000 might be saved each year by practically eliminating tonsillectomy and adenoidectomy and that this money better could be spent elsewhere.

In the wake of our recent epidemic of viral influenza, we all have seen cases of benign acute childhood myositis. I am happy to note that this subject is included in the text though I am disappointed that the value of the serum CPK in confirming the diagnosis is not mentioned.

I recommend this book to all physicians who have children or see children in their practices.

Solomon J. Cohen, M.D.

Illustrated Textbook of Gynaecology

MacKay, Beischer, Cox, and Wood Artarmon, Australia, Holt Saunders, Ltd., 1983. Pp. 496. Illustrated. ($39.50)

This textbook is exactly what the title implies. It is a standard treatise

on basic medical and operative gynecology which contains many photographs of gynecologic conditions. The photographs and illustrations reflect the authors' broad expertise in that they are numerous and reveal a variety of common and not-so-common conditions. Although all the photographs are in black and white, they well illustrate the conditions they wish to present. Hopefully, however, future editions will include some color photographs.

Each chapter starts with an overview of the topic which is to be presented and there is little overlap between subjects. The Australian authors possess the gift of language that their English counterparts do. This ability, to use the mother language with style and wit, often is missing with some of our American writers.

A minor problem may be the reader's unfamiliarity with some of the local instruments, i.e., a Devine's frame (a type of self-retractor). The student, however, does get an insight into modern gynecologic thinking and techniques as practiced on another continent.

The text is recommended to students and gynecologists who wish to broaden their understanding of the subject by being exposed to the state of the art in another modern community.

G.F. Hansen, M.D.

The Law of Medical Practice in Pennsylvania and New Jersey

Frost, Peters, Stahl, Peters, Fineberg, and Kroll. Rochester, NY, The Lawyers Cooperative Publishing Co., 1984. Pp. 1080.

The authors of *The Law of Medical Practice in Pennsylvania and New Jersey* have succeeded in compiling a most instructive and readable text dealing with a difficult subject. This comprehensive volume is a useful and welcome reference and resource tool for physicians, attorneys, hospital administrators, insurance professionals, and others wishing to acquire knowledge of medicolegal matters.

The text addresses various state regulations, statutes, and judicial decisions that concern the entire spectrum of medical practice in New Jersey and Pennsylvania. The book begins with chapters covering current issues affecting medical practice starting with a brief history of the medical system in the United States and encompassing issues such as medical education, health care facilities, hospital administration and regulation, and medical staff issues.

Chapters 4 to 8 perhaps are the most useful to physicians and attorneys. Chapter 4 presents a thoroughly referenced and comprehensive overview of the law of medical malpractice and the litigation system as both have evolved in New Jersey and Pennsylvania. Chapter 5 presents useful information with regard to physician licensure in both states. Chapters 6 and 7 set forth in detail the various regulatory requirements in both states, including public health matters, reporting requirements, controlled substances, and a review of the laws and situations which might expose a physician to criminal liability. The final chapter is a thought-provoking presentation illustrating a wide range of medical problems requiring the application of ethical decision making.

The 26 appendices cover many areas discussed in the text and include schedules of controlled substances in both states, a legal glossary, codes of ethics, standard medical abbreviations, sample legal documents, and sample medical records.

The authors are to be congratulated for their scholarly yet practical approach to a most difficult subject.

James E. George, M.D., J.D.

Review of Medical Microbiology

C. Jawetz, J.T. Melnick, E.A. Adelberg (eds). Los Altos, CA, Lange Medical Publications, 1984. Pp. 557. ($18.50)

This is the 16th edition of the very popular medical microbiology handbook which first was published in 1954 by the same authors; every two years a new edition is produced so that the material is current.

This edition contains the latest materials of acquired immunodeficiency syndrome genetics, virology, and chemotherapy. The literary style is unchanged with every line "chockful" of information and facts, a superb manner for reviewing material. On the other hand, medical students seeing this material for the first time may be overwhelmed by the condensation and lack of flow of material. The success of this series is illustrated by the translation into 12 languages. In 535 pages, every phase of basic and medical microbiology is reviewed. The present outline, photographs, charts, and references are first rate.

This series is a favorite of mine and my son—a medical student.

Leon G. Smith, M.D.

Drs. Anson; Barach; Barbarosh; Bianco; Bornstein; Cassidy; Franz; Grieco; Keates; Laufenberg; Petrosino; Pores; Rosen; Rossi; Sawyer; Sciortino; Spivack; Williams

Dr. Leon J. Anson

A general practitioner in Garwood for almost 40 years, Leon J. Anson, M.D., died on June 21, 1984, at his home in Mountainside. Born in 1913, Dr. Anson received his medical degree from the Medical College of Virginia in 1938. He was a member of our Union County component, and board certified in family practice. Prior to his retirement in 1978, Dr. Anson had been affiliated with Overlook Hospital, Summit. He served as town physician in Garwood for several years and was police surgeon in Mountainside for almost 15 years.

Dr. Richard L. Barach

The head of radiology at The Medical Center at Princeton, Richard L. Barach, M.D., died on July 2, 1984. In addition to his duties at The Medical Center, Dr. Barach was a consultant for the Carrier Foundation, Belle Mead, and Princeton University. Born in 1922, Dr. Barach earned his medical degree from Yale University School of Medicine in 1949. For the past 25 years, Dr. Barach had made his home in Princeton. A member of our Mercer County component and of the American Medical Association, Dr. Barach was a Fellow of the American College of Radiology and a Diplomate of the American Board of Radiology.

Dr. Allan B. Barbarosh

At the untimely age of 48, Allan B. Barbarosh, M.D., died of cancer on June 25, 1984, in Seattle, Washington. An obstetrician/gynecologist in Dover, Dr. Barbarosh was born in Newark, and was graduated from Chicago Medical School, Illinois, in 1961. He was a member of our Morris County component, and of the American Medical Association. Dr. Barbarosh was board certified in his specialty, and a Fellow of the American College of Obstetricians and Gynecologists. He had been affiliated with Dover General Hospital, and was chairman of their department of obstetrics and gynecology.

Dr. John J. Bianco

Word has been received of the death of John James Bianco, M.D. Born in 1915, Dr. Bianco was graduated from Temple University School of Medicine, Philadelphia, in 1941. A retired member of our Cumberland County component, living in Florida, Dr. Bianco was a member of the American Medical Association, a Fellow of the American College of Surgeons, and a Diplomate of the American Board of Obstetrics and Gynecology.

Dr. Paul K. Bornstein

A member of our Monmouth County component, Paul Kenneth Bornstein, M.D., died on June 15, 1984. An internist, with an office in Asbury Park for many years, Dr. Bornstein was born in 1910 in Paterson. He received his medical education at Indiana University School of Medicine, Indianapolis, Indiana, graduating in 1933. Dr. Bornstein was board certified in internal medicine, and was a Fellow of the American College of Physicians and of the American College of Cardiology. He had been affiliate with Monmouth Medical Cente Long Branch; Metropolitan Hospita New York City; and Paul Kimba Hospital, Lakewood. Dr. Bornstei also served as a consultant to number of hospitals including De borah Heart and Lung Cente Browns Mills. Dr. Bornstein was recipient of MSNJ's Golden Mer Award in 1983 in recognition of 5 years of medical practice.

Dr. Herbert E. Cassidy

At the age of 56, Herbert Eugen Cassidy, M.D., a member of ou Hudson County component, died o May 31, 1984. Graduating from th State University College of Medicin New York, in 1956, Dr. Cassidy oper ed a practice specializing in ped atrics in northern New Jersey. Du ing his career, Dr. Cassidy was a filiated with Jersey City Medic Center and Bayonne Hospital. D Cassidy was a member of the Amer can Medical Association and a Fe low of the American College Sports Medicine.

Dr. Ronald L. Franz

At the untimely age of 36, Rona Leslie Franz, M.D., died July 1 1984. Born in New York, Dr. Fran received his medical education fro the Free University of Brussel Belgium in 1969. He completed a internship at Coney Island Hospita New York, in 1977 and a residenc in 1978. At the time of his death, D Franz was an internist with a pr vate practice in Morrisville, Pen sylvania. Dr. Franz was a member our Mercer County component an of the American Geriatric Societ He was affiliated with Helene Ful Medical Center, Trenton.

Dr. Emil H. Grieco

We just have learned of the deat on October 20, 1983, of Emil Hen Grieco, M.D., a member of ou Hudson County component. Born i 1907 in Bayonne, Dr. Grieco r ceived his medical degree from Ne York University School of Medicir in 1933, and returned to his nati city where he established a practic in cardiology. He was a member the American Medical Association, Fellow of the American College Physicians, and a Diplomate i internal medicine. He had been a

filiated with Bayonne Hospital, serving for several years as the director of the department of medicine. In 1983, Dr. Grieco received MSNJ's Golden Merit Award, honoring his 50 years in medicine.

Dr. George H. Keates

George H. Keates, M.D., an internist in Linwood for the past 22 years, died in Shore Memorial Hospital, Somers Point, at the untimely age of 53, on June 7, 1984. Born in Atlantic City, Dr. Keates received his medical degree from Temple University School of Medicine, Philadelphia, in 1956. Dr. Keates was affiliated with Shore Memorial Hospital, and had served as president of the hospital staff in 1975. He had been medical director of the Linwood Convalescent Center, and was active in community affairs having served as school physician for the Linwood public school system and for Oakcrest High School. Dr. Keates also was a certified aviation medical examiner for the Federal Aviation Administration.

Dr. Joseph W. Laufenberg

Word has been received of the death of Joseph William Laufenberg, M.D., on May 5, 1984. Born in 1915, Dr. Laufenberg earned his medical degree at Hahnemann Medical College, Philadelphia, in 1941. An abdominal surgeon, Dr. Laufenberg was affiliated with Helene Fuld Medical Center, Trenton. A retired member of our Mercer County component and a member of the American Medical Association, Dr. Laufenberg retired to Plumstead Township three years ago.

Dr. Carmen P. Petrosino

Carmen Patrick Petrosino, M.D., died on February 15, 1984. A member of our Hudson County component, Dr. Petrosino was an obstetrician, with a practice in Hoboken. He was affiliated with Riverside Hospital, Secaucus, and St. Mary Hospital, Hoboken. Graduating in 1950 from the University of Bologna, Italy, Dr. Petrosino came to the United States in 1953. Dr. Petrosino was a Diplomate of the American Board of Obstetrics and Gynecology, a Fellow of the American College of Obstetrics and Gynecology and of the American College of Surgery, and a member of the American Medical Association.

Dr. Ira H. Pores

Word recently was received of the death on February 12, 1984, of Ira Howard Pores, M.D., a member of our Essex County component. Only 39 years old at the time of his death, Dr. Pores was born in New York City and received his medical degree from the State University of New York at Buffalo in 1973. He was a cardiologist with offices in Millburn. Dr. Pores was a member of our Essex County component, and had been board certified in internal medicine.

Dr. Charles D. Rosen

An internist in East Orange for 48 years, Charles Daniel Rosen, M.D., died in East Orange General Hospital on June 9, 1984. Born in New York City in 1910, Dr. Rosen was graduated from Long Island College of Medicine, Brooklyn, in 1935. He was a member of our Essex County component, a member of the American Medical Association, and a Fellow of the American College of Chest Physicians. He had been affiliated with Presbyterian Hospital, Newark; East Orange General Hospital; and the Geriatric Center, Belleville.

Dr. John R. Rossi

John Richard Rossi, M.D., a retired member of our Hudson County component, died on March 2, 1984. Born in 1910, Dr. Rossi received his medical degree from the Faculty of Medicine of Rome, Italy in 1938. He completed an internship at St. Francis Hospital, New York. An anesthesiologist, Dr. Rossi was affiliated with Bayonne Hospital during his career and served as president of the Bayonne Medical Society in 1959.

Dr. Blackwell Sawyer

In his 85th year, Blackwell Sawyer, M.D., died on June 24, 1984, at Community Memorial Hospital, Toms River. Born in Elizabeth City, North Carolina, Dr. Sawyer received his medical degree from Jefferson Medical College in 1924. He practiced family medicine in Toms River for over 40 years until 1970 when he moved to Island Heights. Dr. Sawyer was a member of our Ocean County component, and a member of the American Medical Association. He was affiliated with Paul Kimball Hospital, Lakewood, and Community Memorial Hospital, Toms River. In 1948, Dr. Sawyer received the National Outstanding Country Doctor Award.

Dr. Joseph Sciortino

At only 63 years of age, Joseph Sciortino, M.D., died at United Hospitals Medical Center, Newark, on June 10, 1984. Dr. Sciortino was born in Bellefonte, Pennsylvania, and was graduated from the Faculty of Medicine, University of Palermo, Italy, in 1955. From the age of 7 until 1958, Dr. Sciortino lived in Italy, returning to the United States in that year and establishing his practice in Elizabeth. He was a member of our Union County component, and had been chief anesthesiologist at St. Vincent's Hospital, Montclair, and on the staff at Alexian Brothers Hospital, Elizabeth.

Dr. David Spivack

A senior member of our Union County component, David Spivack, M.D., died June 24, 1984. A native of New York City, Dr. Spivack received his medical degree from New York University's College of Medicine in 1933. He established a practice in general surgery in Elizabeth, and had been affiliated with St. Elizabeth's, Alexian Brothers, and Elizabeth General Hospitals in that city. Dr. Spivack was a Fellow of the International College of Surgeons; in 1983, he received MSNJ's Golden Merit Award in recognition of his 50 years of medical practice. He was 75 years old at the time of his death.

Dr. David P. Williams, Jr.

An internist in Boonton for many years, David Porter Williams, Jr., M.D., died on June 23, 1984. Dr. Williams was born in Bakerstown, Pennsylvania, in 1912, and received his medical degree from Western Reserve University School of Medicine, Cleveland, Ohio, in 1938. He was a member of our Morris County component, and a member of the American Medical Association. He had been affiliated with St. Clare Hospital, Denville, and Riverside Hospital, Boonton.

Style Sheet

The Journal is the official organ of the Medical Society of New Jersey. The goals of* The Journal *are educational and informational. All material published in* The Journal *is copyrighted by MSNJ.

CONTENT

The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports based on unusual clinical experiences; review articles; clinical notes, succinct items on some aspect or new observation or technique of a case experience; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update; and an opinion column. Editorials are prepared by the Editor and by guest contributors on timely and relevant subjects; editorials are the responsibility of the author. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the Editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made in New Jersey.

ASSIGNMENT OF COPYRIGHT

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978), a transmittal letter or a separate statment accompanying material offered to *The Journal* of the Medical Society of New Jersey must contain the following language and must be signed by all authors:

"In consideration of *The Journal* of the Medical Society of New Jersey taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *The Journal*, MSNJ."

SPECIFICATIONS

Submit two **manuscripts** that must be typewritten and double-spaced on 8½" by 11" paper. Statistical methods used in articles should be identified. Acknowledgements will be made only for specific preparation of an essential part of the manuscript.

Authors are asked to seek clarity, accuracy, and originality; attention to details of grammar, spelling, and typing are important.

The **title page** should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

The author should submit a 40-word **abstract** to be used at the beginning of the article.

Tables must be typewritten and double-spaced on separate 8½" by 11" sheets, with a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source; written permission for re publication from the original pub lisher must be submitted. The cos of color photographs must be born by the author.

Generic names should be use with proprietary names indicate parenthetically or as a footnote witl the first use of the generic nam Proprietary names of devices shoul be indicated by the registration sym bol—®.

The **summary** of the article shoul not exceed 250 words; it should cor tain only essential facts.

References should not exceed 3 citations except in review article and should be cited consecutively i the text by numbers in parenthese at the end of the sentence. The refe ence list should be typewritten an double-spaced on separate 8½" b 11" sheets in the numerical order i which they are first cited in the tex The style of reference is that of *Inde Medicus:*

1. Goldwyn RM: Subcutaneou mastectomy. *J Med Soc N* 74:1050-1052, 1977.

2. Dixon WJ, Massey FJ: *Introdu tion to Statistical Analysis.* Ne York, NY, McGraw-Hill, 1969, p 42-48.

PUBLICATION POLICY

Receipt of each manuscript will b acknowledged and a copy delivere to the Editor who refers the paper t one or more members of the Ed torial Board. The final decision is r served for the Editor. No direct co tact between the reviewers and th authors will be permitted, bu authors will be informed of the r viewers' comments. The publicatio lag for original articles may be s months or more. Galley proofs w be submitted to the author for co rection of typographical errors.

REPRINT ORDERS

Reprints may be ordered after th author is notified that the artic has been selected for a specific issu of JMSNJ. A check for the cost reprints including remake charge order is received after due date mu accompany the order.

COMMUNICATIONS

All communications should sent to the Editor, *The Journ* MSNJ, 2 Princess Road, La renceville, NJ 08648.

Kirwan Financial Group, Inc.

Financial Planners
for the
Medical Profession

Investments, Pensions, Insurance, Etc.

- **Honest**
- **Sophisticated**
- **Profusely Referenced**

609-778-4388

CARDIOLOGIST:

Opportunity to practice cardiology with well-established practice conveniently located to a large teaching hospital. Duties include supervising and interpreting treadmills, Holter monitors, 2D and M-Mode echocardiography performed in office, patient examinations, hospital rounds and cardiac catheterizations. Abilities to do streptokinase and/or angioplasty desirable. Excellent beginning salary and fringe benefits. Located in Pennsylvania.

Reply with C-V to Box No. 97, JMSNJ Immediate Opening.

MEDICAL PRACTICE SALES AND APPRAISALS

We specialize in the valuation and selling of medical practices. If interested in buying or selling a medical practice, contact our Brokerage Division at:

Health Care Personnel Consulting, Inc.
403 GSB Building
1 Belmont Avenue
Bala Cynwyd, PA 19004
215-667-8630

Need A Temporary Physician?

CompHealth treats your practice as if it were our own during: vacations, CMEs, recruiting, clinic start-up or other absences.

Want Free Time While You Practice Medicine?

Join CompHealth's Locum Tenens Physician Group.

★

For further information about temporary coverage or locum tenens practice opportunities, call:

CompHealth
A Physician Group

WILSON ROSS, Regional Administrator
244 East Hanover St.
Trenton, NJ 08608
Telephone: 609-392-1111

Don't take a chance with your career...



Emergency Physician Associates is seeking physicians with Emergency Medicine, Internal Medicine and Family Practice backgrounds who are experienced and interested in a challenging career in Emergency Medicine.

We are currently interviewing for positions in N.J., Pa., N.Y., De. and Md.

Send your C.V. in confidence to:
James E. George, M.D.
Emergency Physician Associates
P.O. Box 298
Woodbury, N.J. 08096
Or call Susan L. Hughes, Physician Recruitment at (609) 848-3817.

It's A Major Medical Explosion

The Lakewood, Toms River and Point Pleasant hospitals are all going ahead with major expansion programs... Bricktown opens new facility.

Cross River Professional Center

400 to 2,300 Square Feet

¼ Mile South of Kimball Medical Center

- $12 per square foot
- Graduated rent schedules
- Ownership options available
- Fully landscaped
- Centrally located and 10 minutes to all four major hospitals
- Private entrances and all services available
- Equipment leases available

BARRYMOR ENTERPRISES

Brokers Protected

1200 River Avenue (Route 9), Lakewood, NJ 08701 • (201) 367-2226

IDEAL OFFICE/RESIDENCE
DOCTOR, DENTIST, ORTHODONTIST

Morris County, Rockaway

Custom 4 bedroom ranch, 3 car garage. Fully air-conditioned, fire, smoke and burglar alarmed. Separate for office entrance and large parking area. Excellent for new practitioner or second office. Community in need of all and every type of professional service.

For more information call: Sharon Albeck, Century 21—

Century 21

WAYNE NORMAN ASSOCIATES
20 W. Main St.
Rockaway, New Jersey 07866
201-625-1250



HOME/OFFICE FOR SALE—Madison, N.J. Classic fou bedroom Colonial; seven room office suite with separate en trance; parklike setting; geographically located near all are hospitals. Call: Mrs. Burrows

Lois Schneider Realtor

441 Springfield Avenue
Summit, N.J. 07901

201-227-139

It's Your Affair, So Don't Lift A Finger

Since we want your special day to be carefree just lift the phone and call

Parties Unlimited

Perfect Catering For A Perfect Affair

Trenton, New Jersey
609-890-0778

MEDICAL COMPUTERS

DEC - IBM - TELEVIDEO ALTOS - NCR

THINKING OF COMPUTERIZING YOUR PRACTICE

FBL MEDICAL COMPUTER SPECIALISTS offer a wide variety of hardware/software configurations for ever medical office, hospital and clinic application.

- AUTOMATIC INSURANCE FORM PREPARATION
- ACCOUNTS RECEIVABLE CONTROL
- AUTOMATIC PATIENT RECALL
- PRACTICE MANAGEMENT REPORTS
- CLINICAL RECORDS
- ACCOUNTS PAYABLE
- APPOINTMENT SCHEDULING
- ELECTRONIC CLAIMS SUBMISSION
- WORD PROCESSING
- MEDICARE/MEDICAID BILLING
- GENERAL LEDGER
- INVENTORY

UNIX SOFTWARE AVAILABLE FOR ALTOS AND NCR
MUMPS SOFTWARE AVAILABLE FOR DEC

SPECIALISTS IN MULTI-USER, MULTI-TASKING DATA-BASE MANAGEMENT SYSTEMS

FBL

PROVIDING YOU WITH OVER 15 YEAR OF MEDICAL COMPUTER EXPERIENC

CONSULTING SERVICE AVAILABLE

3 ROUTE 46W, FAIRFIELD, N.J. 07006 201-882-921

CLASSIFIED ADVERTISEMENTS

NESTHESIOLOGIST—Seeks group or artnership, 1976, Far Eastern Univerity Hospital. Available January 1985. elephone 212-345-2822.

NTERNIST—Board certified, board igible cardiologist; 33, trained in Swananz, temporary pacemaker, Echo. Three ears experience internal medicine. Posion wanted in area internal medicine or rdiology. Phone 215-592-1843 or reply Box No. 99, JMSNJ.

NTERNIST—Board eligible, looking for b opportunity or group practice. Availle immediately. 201-463-8571.

BSTETRICS/GYNECOLOGY—Board igible, NJ licensed, subspecialty fellowip experience in Micro-surgery, hysroscopy, infertility, artificial insemination, gyn-endocrinology. Seeks practice portunity, Available now. Write Box No. 3. JMSNJ.

EDIATRICIAN—Board eligible, 33, with years experience in general pediatric ractice, strong neonatal background. vailable July 1985. Desires opportunity New Jersey. Contact Box No. 101, MSNJ.

URGICAL ASSISTANT—Board rtified ophthalmologist would like a sition as a surgical assistant 2 or 3 ys a week. Would prefer Central New rsey, but would consider other lotions in New Jersey—New York area. rite Box No. 98, JMSNJ.

RTHOPAEDIC SURGEON—American aduate, trained at Downstate Medical nter, NY; seeks position solo, group or spital based. Call during business urs 212-819-8706 or write Box No. 0, JMSNJ.

HYSICIAN—Lifetime NJ resident seeks sition in a pediatric group after cometion of postgraduate training. Availle July 1985. Please contact Charles neslaw, 8372 Loveridge Court, Richond, VA. 23229.

ADIOLOGIST—Board certified, trained general diagnosis, nuclear medicine, ecial procedures, CT and ultrasound. vailable full or part-time. Group prace or hospital based, North or Central . Write Box No. 81, JMSNJ.

NEEDED PHYSICIANS—For successful, well known, walk-in medical office center, Central NJ. Full and part time, skilled personable, American trained MDs. Send CV to E. V. McGinley, MD, 1005 N. Washington Avenue, Green Brook, NJ 08812. 201-968-8900.

PHYSICIAN—MD for industrial and occupational health care facility in the South Jersey resort area. Opening November or December. Duties to include emergency follow-up/and return to work treatment, as well as pre-placement and annual physical exams. Send CV to Box No. 95, JMSNJ.

WANTED—RADIOLOGY OFFICE PRACTICE—Board certified radiologist with nine years hospital based experience is seeking to buy into or buy out an active private radiology office practice in Northern or Central NJ. Write Box No. 71, JMSNJ.

FOR SALE—Active Family and Industrial Practice in Northwestern NJ. Close to three hospitals. Office consists of large waiting room, nurses station, three examining rooms, consultation room, laboratory, x-ray and dark room and lavatory. Full basement on 0.6 acre lot. Room for expansion or another building. Asking price $275,000. Call after 8:30 p.m. 201-267-0699.

FOR SALE—Like new ECG portable COMPUT-EK with 2 boxes ECG roll paper, $900. Telephone days 201-750-8474 or nights 201-647-3793.

FOR SALE—Two Hamilton "premiere" examining tables. Never used. Mint condition, $500 each. Call evenings 201-529-3690.

FOR SALE—RECP instrument complete with accessories, JF-IT, in absolutely new condition. Used for a short period. Price quite reasonable and negotiable. Contact: 201-794-8900.

WANTED—Used Medical Office Equipment and Furniture in good condition. Call 201-287-6357 after 7 p.m. or write P. O. Box 1048, Edison, NJ 08817.

FOR RENT—Professional office space for rent. Millburn prestigious building, 775 square feet. On-site parking, on bus route. Call 201-731-1900.

OFFICE FOR SHARE or RENT—New Brunswick, Highland Park area. Furnished, 700 square feet. Ample parking, close to the hospital. Rent $500/month plus utilities. For share $300/month including utilities. Call 201-846-1661 or 572-7553.

OFFICE TO SHARE—Bergenfield. Centrally located, professional building, parking, furnished 900 square feet. Five minutes from hospitals. Call 201-385-8350, Ronny Meier, MD, 297 South Washington Avenue, Bergenfield, NJ 07621.

OFFICE SPACE—Atlantic City. For rent, medical office fully equipped and furnished. 1,300 square feet. Call 609-822-0270.

OFFICE SPACE—Bloomingdale, town of 8000 needs physician, general practice. New medical office, 990 square feet. Two examining rooms, x-ray room, dark room, medical laboratory, consultation room. Off street parking. H/AC. 201-337-4152 or 201-337-3801.

OFFICE SPACE—Livingston. In Modern Professional building, convenient to major highways. Ample parking. Terms negotiable. Available immediately. Contact 201-992-5588.

OFFICE SUITE—Southern Jersey (Gloucester Township, Camden County). For rent in new medical building; 1000 or 2000 square foot suites available. Located in rapidly growing, highly desirable area, near several large hospitals. Ideal for family practice or specialist. Building to be completed late 1984. Call Dr. Ribatsky 609-227-2221.

FOR RENT—West Orange, Office, 850 square feet. Small medical building. Parking, buses, convenient to Route 280 and hospitals. Call 201-676-3030.

FOR RENT—West New York. Professional office, corner location with parking space on Doctors' row. Close to hospital and public transporation. Call 201-278-1000 or 201-947-4333.

TE INFORMATION FOR MEMBERS: $5.00 per insertion up to 25 words; 10 cents each additional word. Payable in advance. **RD COUNT:** Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of nbers, hyphenated words. Count name and address as five words, telephone number as one word, and "Write Box No. 000, JMSNJ" as six words. **COPY DEADLINE:** Fifth of preceding month.

JEMPAC New Jersey Medical Political Action Committee

VOTE.

EXERCISE YOUR RIGHT.

NOVEMBER 6, 1984

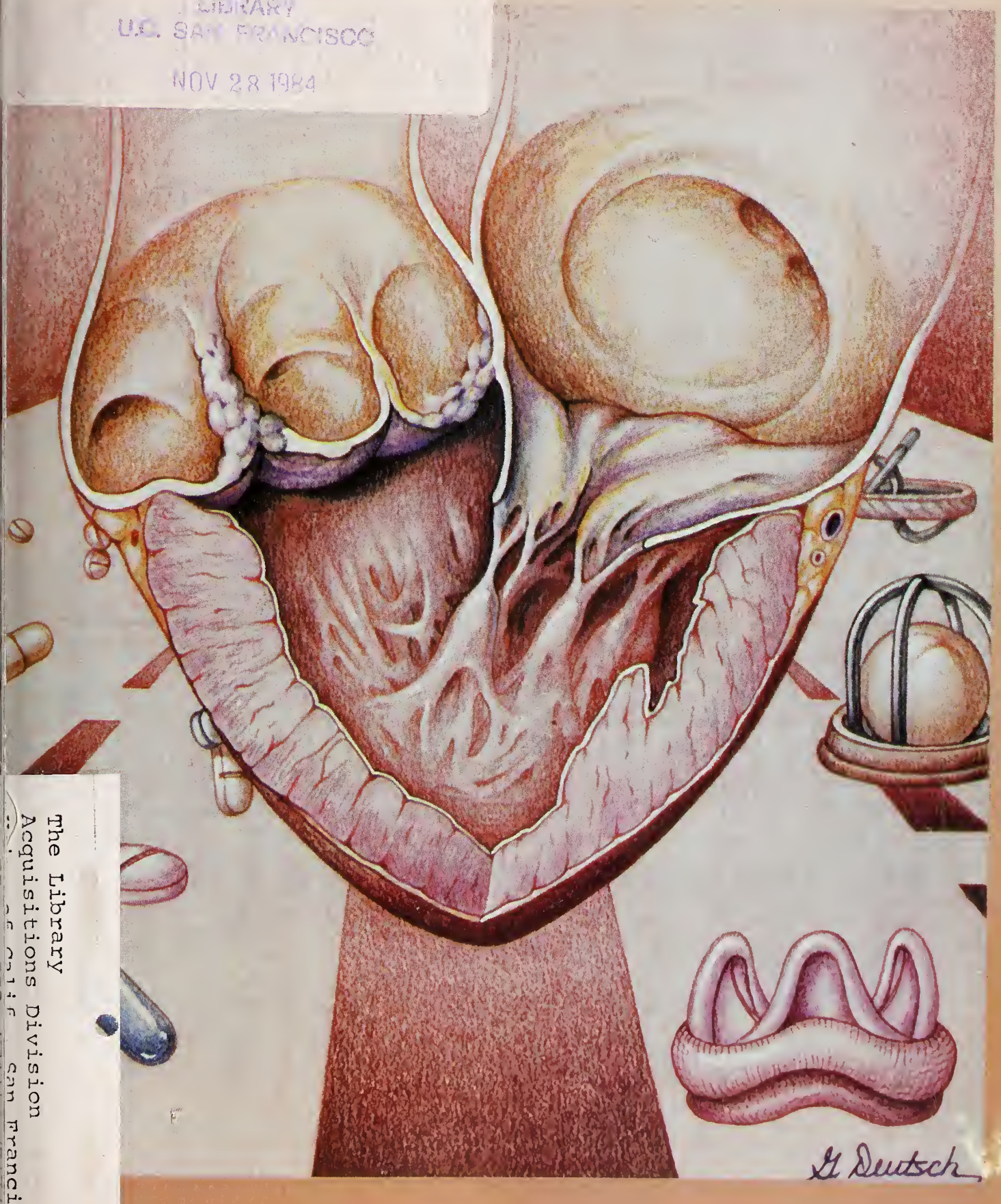
A Public Service of JEMPAC

Copies of JEMPAC and AMPAC reports are filed with the Federal Election Commission and are available for purchase from The Federal Election Commission, Washington, D.C.

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

NOVEMBER 1984

LIBRARY
U.C. SAN FRANCISCO
NOV 28 1984



AORTIC AND MITRAL VALVE REPLACEMENT

The Library
Acquisitions Division
San Francisco

E. & W. BLANKSTEEN
E. & W. BLANKSTEEN AGENCY, INC.

ADMINISTRATORS

THE MEDICAL SOCIETY OF NEW JERSEY

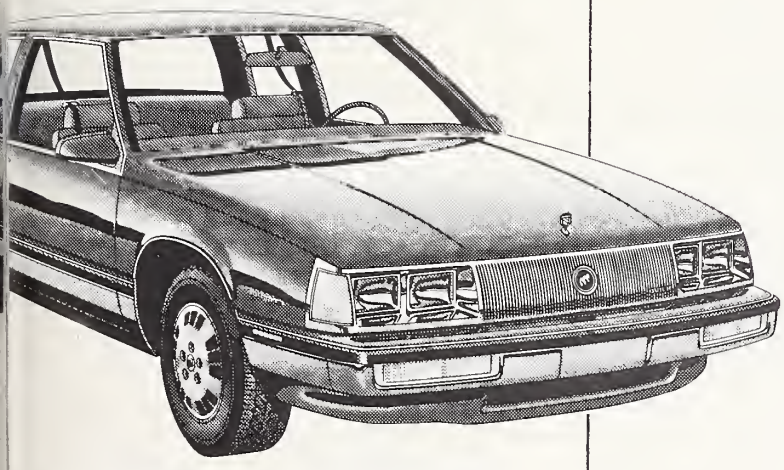
ENDORSED PLANS OF:

LONG-TERM INCOME PROTECTION PLAN
MAJOR MEDICAL
OVERHEAD EXPENSE
HOSPITAL-MONEY
6-POINT HIGH LIMIT ACCIDENT
TERM LIFE
KEOGH

NON-GROUP PROGRAMS OF:

HOMEOWNER'S
OFFICE PACKAGE
LIFE
IRA
PENSION

75 Montgomery Street
Jersey City, N.J. 07201
(201) 333-4340 1-(800) BLANK AG



'85 BUICK ELECTRA 4-DR SEDAN

Here's a car so new that it's the first of the '85's. But thanks to its front-wheel drive, Multi-port Fuel Injection, four-wheel independent suspension, advanced aerodynamics and generously applied electronics, the new Park Avenue will stay on the leading edge of automotive design for many years to come.

PAY NOTHING DOWN & ENJOY 72,000 FREE MILES ON US.

BECAUSE PROFESSIONALS COME FIRST AT FENNESSEY... IT'S THE LEASE WE CAN DO.

Why tie up your precious capital? Drive away today in plush Buick luxury...the modern way, with Fennessey Professional Leasing. Free up your cash. Free yourself from up-front down payments. Budget your car costs conveniently and accurately!

Rt. 202-206 North • Somerville, N.J. 08876
Call 725-3020 •
Open Daily 9-9 • Fri. til 6 • Sat. til 5

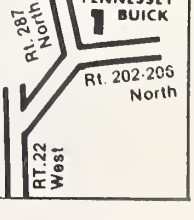
SEE

FENNESSEY

FIRST

PHONE US FOR LIMITED MONEY-SAVING PROFESSIONAL LEASING RATE

BUY	LEASE	RENT	SO EASY TO REACH!
Central Jersey's Largest Selection of New Buicks and Trade Cars!	No Down Payment, 72,000 free miles with full mfrs. car warranty.	Only 29.95 per day for new Buick Skylarks or Skyhawks... always available! 50 free miles.	Only 4 minutes from Somerville



THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

November 1984

Officers and Trustees

PRESIDENT AND CHAIRMAN OF THE BOARD
Frank Y. Watson, M.D. (Essex) ..... Glen Ridge
PRESIDENT-ELECT
Ralph J. Fioretti, M.D. (Bergen) ..... Rochelle Park
FIRST VICE-PRESIDENT
Edward A. Schauer, M.D. (Monmouth) ..... Farmingdale
SECOND VICE-PRESIDENT
Harry M. Carnes, M.D. (Camden) ..... Audubon
IMMEDIATE PAST-PRESIDENT
Alexander D. Kovacs, M.D. (Union) ..... Scotch Plains
SECRETARY
Arthur Bernstein, M.D. (Essex) ..... South Orange
TREASURER
Paul J. Hirsch, M.D. (Somerset) ..... Bridgewater

Trustees

Joel S. Cherashore, M.D. (1986) (Essex) ..... Nutley
Douglas M. Costabile, M.D. (1987) (Union) ..... Murray Hill
Palma E. Formica, M.D. (1987)
(Middlesex) ..... New Brunswick
Harry W. Fullerton, Jr., M.D. (1985)
(Salem) ..... Carney's Point
Frank Gingerelli, M.D. (1986) (Bergen) ..... Hackensack
Michael M. Heeg, M.D. (1987) (Mercer) ..... Trenton
Louis L. Keeler, M.D. (1985) (Camden) ..... Collingswood
John P. Kengeter, M.D. (1987) (Ocean) ..... Toms River
Edwin W. Messey, M.D. (1985) (Burlington) ..... Willingboro
Myles C. Morrison, Jr., M.D. (1985) (Morris) .... Morristown
John J. Pastore, M.D. (1986) (Cumberland) ..... Vineland
Carl Restivo, Jr., M.D. (1987) (Hudson) ..... Jersey City
Bernard Robins, M.D. (1987) (Essex) ..... Springfield
Gerald H. Rozan, M.D. (1987) (Passaic) ..... Wayne

Councilors

FIRST DISTRICT
(Essex, Morris, Union, and Warren Counties)
Edward M. Coe, M.D. (1987) ..... Cranford
SECOND DISTRICT
(Bergen, Hudson, Passaic, and Sussex Counties)
Robert A. Weinstein, M.D. (1986) ..... Newton
THIRD DISTRICT
(Hunterdon, Mercer, Middlesex, and Somerset Counties)
Louis G. Fares, M.D. (1985) ..... Trenton
FOURTH DISTRICT
(Burlington, Camden, Monmouth, and Ocean Counties)
Frederick W. Durham, M.D. (1987) ..... Haddonfield
FIFTH DISTRICT
(Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties)
Paul H. Steel, M.D. (1986) ..... Atlantic City

AMA Delegates

William J. D'Elia, M.D., *Chairman* (1985) ..... Spring Lake
Alfred A. Alessi, M.D. (1986) ..... Hackensack
Frederick W. Durham, M.D. (1986) ..... Haddonfield
Palma E. Formica, M.D. (1986) ..... New Brunswick
Karl T. Franzoni, M.D. (1986) ..... Trenton
John S. Madara, M.D. (1986) ..... Salem
Henry J. Mineur, M.D. (1986) ..... Cranford
Myles C. Morrison, Jr., M.D. (1985) ..... Morristown
Howard D. Slobodien, M.D. (1985) ..... Metuchen

AMA Trustee

James S. Todd, M.D. (Ridgewood) ..... Bergen

Publication Committee

Paul J. Hirsch, M.D., *Chairman*
Dirck L. Brendlinger, M.D.
Frederick B. Cohen, M.D.
A. Olusegun Fayemi, M.D.
La Verne Fioretti
Robert M. MacMillan, M.D.
Leon G. Smith, M.D.

Editor

Arthur Krosnick, M.D.

Managing Editor

Geraldine R. Hutner

Assistant Managing Editor

Dorothy J. Griffith

Advertising Manager

E. Elizabeth Cookson

Graphic Artist

Frank Cecala

Executive Director

Vincent A. Maressa

Executive Director Emeritus

Richard I. Nevin

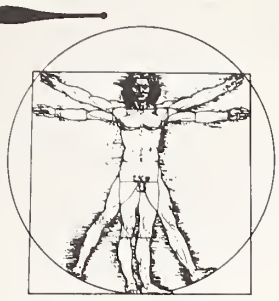
Editorial Board

Jerome Abrams, M.D. (Obstet/Gynecol)
Joseph Alpert, M.D. (Vasc Surg)
Harold Arlen, M.D. (Otolaryngol)
Alfonse Cinotti, M.D. (Ophthalmol)
Robert Dodelson, M.D. (Nephrol)
Norman H. Ertel, M.D. (Int Med/Endocrinol)
Daniel P. Greenfield, M.D. (Psychiat)
Christine E. Haycock, M.D. (Sports Med)
Monroe S. Karetzky, M.D. (Pulmon Med)
Avrum L. Katcher, M.D. (Pediatr)
Stanley C. Leonberg, Jr., M.D. (Neurol)
Joel D. Levinson, M.D. (Gastroenterol)
Joseph A. Lieberman, III, M.D. (Fam Med)
Alan J. Lippman, M.D. (Oncol)
Henry R. Liss, M.D. (Neurosurg)
Geobel A. Marin, M.D. (Int Med/Gastroenterol)
Donald G. McKaba, M.D. (Allergy)
Robby Meijer, M.D. (Plas Surg)
Frank T. Padberg, Jr., M.D. (Surg)
Christopher A. Papa, M.D. (Dermatol)
Edwin L. Rothfeld, M.D. (Cardiol)
Benjamin F. Rush, Jr., M.D. (Surg)
Morris H. Saffron, M.D. (Med His)
Mark M. Singer, M.D. (Int Med/Endocrinol)
Sheldon D. Solomon, M.D. (Rheum)
Lloyd N. Spindell, M.D. (Radiol)
A. Arthur Sugerman, M.D. (Psychiat)
Stephen F. Wang, M.D. (Pediatr)
Edwin S. Wilson, M.D. (Radiol)
Louis S. Zeiger, M.D. (Nucl Med)
Robert B. Zufall, M.D. (Urol)

The Journal of the Medical Society of New Jersey (ISSN-0025-7524) is published monthly (since 1904) exc semimonthly in July (13 issues), under direction of the Committee on Publication, by the Medical Society of N Jersey, Two Princess Road, Lawrenceville, NJ 08648. Printed in East Stroudsburg, PA, by the Hughes Print Co. Whole number of issues 968. Member's subscription ($10) is included in Society dues. Rates for nonmemb $20; outside USA add $7.50 for postage. Single copies, $2. Address communications to *The Journal* MSNJ, T Princess Road, Lawrenceville, NJ 08648, (609) 896-1766. Second-class postage paid at Trenton, NJ, and additio entry office.

Copyright 1984 by the Medical Society of New Jersey.

MEDIA PLUS



...the **only** name you need to remember in BIOMEDICAL COMMUNICATIONS.

- medical illustrations (including anatomical, surgical, scientific, and legal)
- charts and graphs
- patient education art work
- cartooning
- 35mm slide productions (including slide tapes and multi-media shows)
- medical and biological photography
- video tape productions

Effectively communicating your ideas is our goal.

Media Plus
64 Conkling St.
Basking Ridge, NJ 07920
(201) 766-7747

It's Your Affair, So Don't Lift A Finger

Since we want your special day to be carefree just lift the phone and call

Parties Unlimited

Perfect Catering For A Perfect Affair

Trenton, New Jersey
609-890-0778

Note: If you're new to medical practice in N.J. . . .

You don't have to buy commercial malpractice insurance

AMES S. TODD, M.D., *Chairman/Board of Directors, Medical Inter-Insurance Exchange of New Jersey*

AS you made your decision to establish yourself n New Jersey, you no doubt heard horror tories about our professional liability insurance roblems. The legal risks we assume in this usiness have grown so far out of proportion hat many commercial underwriters have been imply unable to cope, resulting in abrupt and often untimely suspension of coverage.

As a new practitioner in this State, either elocating or just beginning your professional areer, you have an alternative to commercial nsurance. The Medical Inter-Insurance xchange provides an opportunity to build our new practice on the most secure footing ossible with long-term peace of mind.

Founded in 1977 at the peak of the "premium crisis," the Exchange is a wholly doctor-owned cooperative organization through which we insure *ourselves* for our own sake. Membership has grown to two-thirds of all practicing physicians and surgeons in the state. Because we're in it for security — *not for profit* — we can provide for ourselves the absolute best available insurance product for the money. Every dollar we take in goes toward protection (no sales commissions) and every dollar left over is returned to us — in cash.

You owe it to yourself to know your options and the practicalities of each. We're here to help you sort them all out. Call and talk directly to our Vice President and Director of Policyholder Services, Bill Reilly, **TOLL FREE (in N.J.) 800-257-6288** or (609) 896-2404 from other areas. We look forward to hearing from you.

A professional service message from the **Medical Inter-Insurance Exchange** of N.J.
Two Princess Road, Lawrenceville NJ 08648
(609) 896-2404

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY
NOVEMBER 198

FEATURES

919 Membership Newsletter
923 Professional Liability Commentary
929 Editorial
931 Hospital Governing Boards

CONTRIBUTIONS

935 Maternal Deaths in New Jersey—1982
G.F. Hansen, M.D., and M. Gregory, M.D., Newark
941 Ceftriaxone, A Third Generation Cephalosporin
E.S. Johnson, M.D., M. Fedder, M.D., L.G. Smith, M.D., Newark
949 Aortic and Mitral Valve Replacement: Part 1
P.J. Olivieri, M.D., and J.B. Kostis, M.D., New Brunswick
959 Indium-111-Oxine-Labeled Leukocyte Imaging
F.M. Palace, M.D., and R.F. Crystal, M.D., Morristown
967 Pharmacological Basis of Therapeutics:
Insulin-Like Growth Factors
M.A. Brostrom, Ph.D., Piscataway
973 Pediatric Briefs
R.H. Rapkin, M.D., F.C. Behrle, M.D., S.C. Sun, M.D., Newark

DOCTORS' NOTEBOOK

977 Trustees' Minutes: September 16, 1984
979 UMDNJ Notes, *Stanley S. Bergen, Jr., M.D.*
979 MSNJ Auxiliary, *Grace Gellman*
980 AMNJ Report, *Robert S. Rigolosi, M.D.*
980 Physicians Seeking Location in New Jersey

MSNJ DEPARTMENTS

983 1984-1985 Committees & Councils
988 Statement of Ownership, Management, and Circulation
991 CME Calendar
995 Letters to the Editor
996 Book Reviews
1005 Obituaries
1007 Information for Authors

On The Cover: Drs. Olivieri and Kostis discuss the history of aortic and mitral stenosis and aortic and mitral regurgitation in the first part of their study on valve replacement, beginning on page 949.



Motrin reduces inflammation, pain ...and price

New low price...major savings

The dramatic reduction in the price of *Motrin* Tablets means substantial savings from now on for your patients and for patients all across the country for whom *Motrin* Tablets are prescribed.

Motrin is priced lower than Clinoril, Feldene, or Naprosyn.

The price of *Motrin* Tablets to pharmacies has been reduced as much as 35%. Patients taking the average dosage should now pay less for therapy with *Motrin* Tablets than for almost any other nonsteroidal anti-inflammatory drug you prescribe...less, for example, than for Clinoril, Feldene, or Naprosyn. And, of course, all strengths of *Motrin* Tablets continue to be available by prescription only.

Please see the following page for a brief summary of prescribing information.

Motrin® 400 & 600 mg TABLETS
ibuprofen

Good medicine...good value

© 1984 The Upjohn Company

The Upjohn Company **Upjohn** Kalamazoo, Michigan 49001

Motrin® Tablets (ibuprofen)

Contraindications: Anaphylactoid reactions have occurred in individuals hypersensitive to *Motrin* Tablets or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin, iodides, or other nonsteroidal anti-inflammatory agents.

Warnings: Peptic ulceration and GI bleeding, sometimes severe, have been reported. Ulceration, perforation and bleeding may end fatally. An association has not been established. Use *Motrin* Tablets under close supervision in patients with a history of upper gastrointestinal tract disease, after consulting ADVERSE REACTIONS. In patients with active peptic ulcer and active rheumatoid arthritis, try nonulcerogenic drugs, such as gold. If *Motrin* Tablets are used, observe the patient closely for signs of ulcer perforation or GI bleeding.

Chronic studies in rats and monkeys have shown mild renal toxicity with papillary edema and necrosis. Renal papillary necrosis has rarely been shown in humans treated with *Motrin* Tablets.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue *Motrin* Tablets and the patient should have an ophthalmologic examination, including central visual fields and color vision testing.

Fluid retention and edema have been associated with *Motrin* Tablets; use with caution in patients with a history of cardiac decompensation or hypertension. In patients with renal impairment, reduced dosage may be necessary. Prospective studies of *Motrin* Tablets safety in patients with chronic renal failure have not been done.

Motrin Tablets can inhibit **platelet aggregation** and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and on anticoagulant therapy.

Patients should report signs or symptoms of **gastrointestinal ulceration** or bleeding, skin rash, weight gain, or edema.

Patients on prolonged **corticosteroid therapy** should have therapy tapered slowly when *Motrin* Tablets are added.

The antipyretic, anti-inflammatory activity of *Motrin* Tablets may mask inflammation and fever.

As with other nonsteroidal anti-inflammatory drugs, borderline elevations of liver tests may occur in up to 15% of patients. These abnormalities may progress, may remain essentially unchanged, or may be transient with continued therapy. Meaningful elevations of SGPT or SGOT (AST) occurred in controlled clinical trials in less than 1% of patients. Severe hepatic reactions, including jaundice and cases of fatal hepatitis, have been reported with ibuprofen as with other nonsteroidal anti-inflammatory drugs. If liver disease develops or if systemic manifestations occur (e.g. eosinophilia, rash, etc.), *Motrin* should be discontinued.

Drug interactions. *Aspirin:* used concomitantly may decrease *Motrin* blood levels.

Coumarin: bleeding has been reported in patients taking *Motrin* and coumarin.

Pregnancy and nursing mothers: *Motrin* should not be taken during pregnancy or by nursing mothers.

Adverse Reactions: The most frequent type of adverse reaction occurring with *Motrin* is gastrointestinal of which one or more occurred in 4% to 16% of the patients.

Incidence Greater than 1% (but less than 3%)—Probable Causal Relationship

Gastrointestinal: Nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence); **Central Nervous System:** Dizziness,* headache, nervousness; **Dermatologic:** Rash* (including maculopapular type), pruritus; **Special Senses:** Tinnitus; **Metabolic/Endocrine:** Decreased appetite; **Cardiovascular:** Edema, fluid retention (generally responds promptly to drug discontinuation; see PRECAUTIONS).

Incidence less than 1%—Probable Causal Relationship**

Gastrointestinal: Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, melena, gastritis, hepatitis, jaundice, abnormal liver function tests; **Central Nervous System:** Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma; **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia; **Special Senses:** Hearing loss, amblyopia (blurred and/or diminished vision, scotomata, and/or changes in color vision) (see PRECAUTIONS); **Hematologic:** Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit; **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations; **Allergic:** Syndrome of abdominal pain, fever, chills, nausea and vomiting; anaphylaxis; bronchospasm (see CONTRAINDICATIONS); **Renal:** Acute renal failure in patients with pre-existing significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria; **Miscellaneous:** Dry eyes and mouth, gingival ulcer, rhinitis.

Incidence less than 1%—Causal Relationship Unknown**

Gastrointestinal: Pancreatitis; **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri; **Dermatologic:** Toxic epidermal necrolysis, photoallergic skin reactions; **Special Senses:** Conjunctivitis, diplopia, optic neuritis; **Hematologic:** Bleeding episodes (e.g., epistaxis, menorrhagia); **Metabolic/Endocrine:** Gynecomastia, hypoglycemic reaction; **Cardiovascular:** Arrhythmias (sinus tachycardia, sinus bradycardia); **Allergic:** Serum sickness, lupus erythematosus syndrome, Henoch-Schonlein vasculitis; **Renal:** Renal papillary necrosis.

*Reactions occurring in 3% to 9% of patients treated with *Motrin*. (Those reactions occurring in less than 3% of the patients are unmarked.)

**Reactions are classified under *"Probable Causal Relationship (PCR)"* if there has been one positive rechallenge or if three or more cases occur which might be causally related. Reactions are classified under *"Causal Relationship Unknown"* if seven or more events have been reported but the criteria for PCR have not been met.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine so alkaline diuresis may be beneficial.

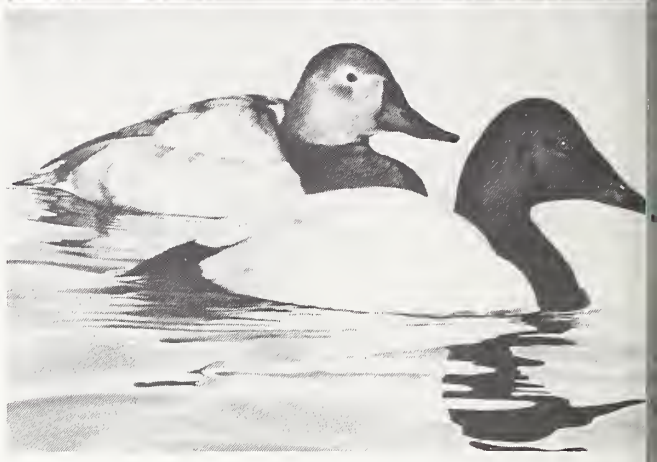
Dosage and Administration: Rheumatoid arthritis and osteoarthritis. Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Do not exceed 2400 mg per day. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary.

Caution: Federal law prohibits dispensing without prescription. MED B-7-S

Motrin is a registered trademark of The Upjohn Manufacturing Company

Upjohn The Upjohn Company
Kalamazoo, Michigan 49001

"FIRST OF STATE"
1984 NEW JERSE
DUCK STAMP PRIN



Federal and state duck stamp prints are amo
the most desired collections in the U.S. T
federal program is now 51 years old and is worth
excess of $80,000.00! A complete set of "first
state" duck stamp print is worth $16,000.00! N
New Jersey is offering their "first". The design is
a pair of Canvasbacks resting in water. T
Hirata's painting is crisp, clear and classic!

A framed New Jersey Duck Stamp Print is
perfect addition to your home or office.

Call collect (609) 983-3771

Ask published and national authority J
McCaddin for the possible tax advantages in c
lecting duck stamp prints.

MARLTON SPORT 'N WILDLIFE GALLERY



**2 North Maple A
Marlton, NJ 080
(609) 983-3771**

Print with two mint stamps $142.50 _____
Executive "color" Remarque Edition w/mints
w/signed w/medallion & rem. $561.50 _____

**Framing—Two stamp openings $ 80.00*
Executive Edition $110.00

Mail Order—Add $7.50 for framed UPS delivery
Add $5.00 for unframed UPS delivery

Signature _____
Name _____ Phone _____
Address _____
City _____ State _____ Zip _____
Credit Card # _____ Exp. Date _____

VISA/MC Accepted

*All matting is to museum specifications with hand-stai
Walnut. Medallion editions will be framed in Mahogany w
gold lip to accent the medallion.

MEMBERSHIP NEWSLETTER

MSNJ

THE MEDICAL SOCIETY OF NEW JERSEY VOLUME 16

EGALIZE USE OF HEROIN

The AMA is opposed to the proposed House floor ction on H.R. 5290 which would establish a four-year rogram under which heroin would be made available o hospitals and hospice pharmacies for terminally ill ancer patients with intractable pain.

The Association opposes this legislation on three rounds: 1) Heroin is not necessary since it is no more ffective than analgesics now available, including)ilaudid HP; 2) Congressional action would establish n inappropriate precedent by pre-empting the consumer protective provisions of the Food, Drug, and)osmetic Act that are designed to assure the safety nd effectiveness of available drug products based on ound scientific data; and 3) The availability of heroin ould substantially increase the security problems of ospitals and hospices.

MA LAW SUIT—MEDICARE FEE FREEZE

The AMA filed suit on September 21, 1984, in the 'ederal Court, Southern District, Indiana, against the ederal government and the Secretary of HHS regarding the Medicare fee freeze. The plaintiffs will be the MA and the Indiana Medical Society and certain Medicare beneficiaries. The complaints are as follows:) The plaintiffs consider the fee freeze unconstitutional; it violates equal protection laws; 2) It effectively enies beneficiaries the right to select their own physician; and 3) It creates unlawful interference in the ontract rights of physicians and Medicare beneficiaries. The AMA also is going to file for a preliminary njunction against the October deadline for signing. 'hey are claiming the carriers have been unable to rovide physicians with the information they need on nusual fees. This prevents the physicians from knowng at what rate they would be reimbursed if they igned the agreement.

MA COMMENTS ON FEDERAL LEGISLATION ND REGULATIONS

Direct Medicare Reimbursement for Services Performed by Registered Nurse Anesthetists. In a letter o the House and Senate sponsors of H.R. 4683 and . 1772, authorizing direct Medicare reimbursement o registered nurse anesthetists, the AMA stated that the legislation is unnecessary due to a recent modification in the law authorizing cost-based reimbursement for services performed by nurse anesthetists, through September 30, 1987, and calling for a study on Medicare reimbursement methods that will not discourage the use of nurse anesthetists. (Letter to Representatives Frank, Jacobs, Waxman and to Senators Matsunaga, Dole, Durenberger, July 30, 1984.)

Restructuring the Social Security Administration as an Independent Agency. In a statement to the Ways and Means Committee, the AMA stated that it believes that any discussion concerning major reorganization of the Department of Health and Human Services should include strong consideration of establishing a separate U.S. Department of Health. The increasingly complex nature of medical and other health issues facing the federal government requires knowledgeable management and direction. Such direction and management could be provided if a separate department is created to focus on these important and sensitive issues. Until such time as a separate department is established, the AMA supports H.R. 5438, which elevates the Assistant Secretary for Health to the position of Undersecretary of Health. (Statement, Subcommittee on Social Security, House Ways and Means Committee, August 1, 1984.)

Medicare Program Payment to Health Maintenance Organizations and Competitive Medical Plans. The AMA submitted comments to HCFA on a proposed rule to implement Medicare reimbursement for eligible health maintenance organizations (HMO) and competitive medical plans (CMP). The Association called for modifications to the proposed rule to "assure that beneficiaries will be informed fully of the consequences of a decision to join or not join an HMO or CMP. We also are concerned that, while the law authorizing such organizations to provide health care services requires these organizations to make 'adequate provision against the risk of insolvency,' this proposed rule does not provide an adequate means of assuring beneficiaries such protection." In addition, the AMA commented on the use of the term "physician" in the proposed rule, the definition of "emergency services," and marketing activities allowed for HMOs and CMPs. (Letter and statement to Health Care Financing Administration, August 1, 1984).

PHYSICIANS' SERVICES COMPONENT OF CONSUMER PRICE INDEX

The purpose of the physicians' services component of the Consumer Price Index (CPI) is to measure changes in physicians' fees paid out of pocket by consumers. This has three important implications: First, the index does not deal with issues of utilization. If more people visit physicians as a result of a flu epidemic, this will have no direct effect on the index. Second, to the degree that consumers' use of physicians' services are covered by third parties, this does not enter into the data base for construction of the price index for physician services. Third, given the out-of-pocket orientation of the survey methodology, the physicians' services component systematically underrepresents services delivered by physicians who specialize in areas for which the great part of charges are covered by insurance.

AMA STATEMENTS

National Minimum Drinking Age. The AMA supported a bill, H.R. 2441, which would encourage states to raise their minimum drinking age to 21 by withholding federal highway funds from states which do not comply. (Letter to Congressman John E. Porter, March 1, 1984).

Uniform Minimum Drinking Age Act of 1984. The AMA commented on S. 2263, a bill which would encourage states to raise the minimum drinking age to 21 by reducing federal highway funds for each year that a state does not comply. While supporting the purposes of the bill, the AMA urged stronger sanctions against states which fail to raise the drinking age to 21 years. (Letter to Senator Frank R. Lautenberg, March 16, 1984.)

Airline Medical Kits. The American Medical Association recommended that the following minimum diagnostic and therapeutic equipment be required on all commercial airline flights: a stethoscope, a sphygmomanometer, airways, splints, tongue blades, and flashlight. The AMA also called upon the FAA to conduct a study to determine the number, frequency, and types of inflight medical emergencies so as to determine the specific need for extended medical kits and the most appropriate contents for such kits. (Letter to Federal Aviation Administration, January 6, 1984.)

Motor Vehicle Safety. The AMA urged the immediate implantation of a program requiring passive restraints, preferably air cushions, in all new automobiles. The Association also reaffirmed its support for child passenger restraint laws, for mandatory seat belt utilization laws, and for legislative action to promote the availability of effective seat belts in all motor vehicles in public use. (Letter to Department of Transportation, June 22, 1984.)

Dangerous Drug Diversion Control Act of 1984. The AMA expressed concern over the problem of diversion of controlled substances to illicit channels and awareness of the adverse medical, economic, and social consequences of such activity. The Association also described a number of measures it has undertaken t combat illicit drug diversion including the develop ment of the Prescription Abuse Data Synthesis mode The AMA supported the general thrust of H.R. 469 a bill that would amend the Controlled Substances Ac and suggested modifications that would strengthe the bill. In addition, the Association supported ade quate funding for the Drug Enforcement Adminis tration. (Statement to Crime Subcommittee of th House Judiciary Committee, February 22, 1984.)

Physician Reimbursement Under Medicare. Th AMA testified on the success and growth of the Med care program, the growth of health care costs, and ho physician reimbursement and beneficiary liability i determined under Medicare. The testimony discusse the Association's support for a one-year freeze in phy sicians' fees and that this voluntary freeze was "in lin with a one-year freeze of Medicare payments to phy sicians as proposed by the President in his recen budget." The Association opposed proposals to modi physician reimbursement by basing payments o diagnosis related groups (DRG), mandating assign ment, and through the "participating physician" con cept. (Testimony before Senate Special Committee o Aging, March 16, 1984.)

PROPOSED RULE: MEDICAID ELIGIBILITY

The Division has proposed a rule concerning a pa tient's financial eligibility for Medicaid. The propos indicates that there is no reimbursement for service performed after termination of eligibility. This stand ard conforms to the New Jersey Medicaid law (N.J.S. 30:4D-3i, j) which requires that persons must b financially eligible for AFDC, SSI, etc. in order to recei Medicaid services. This proposal has appeared in th *New Jersey Register.* (August 20, 1984, at 16 NJ 2219(a)).

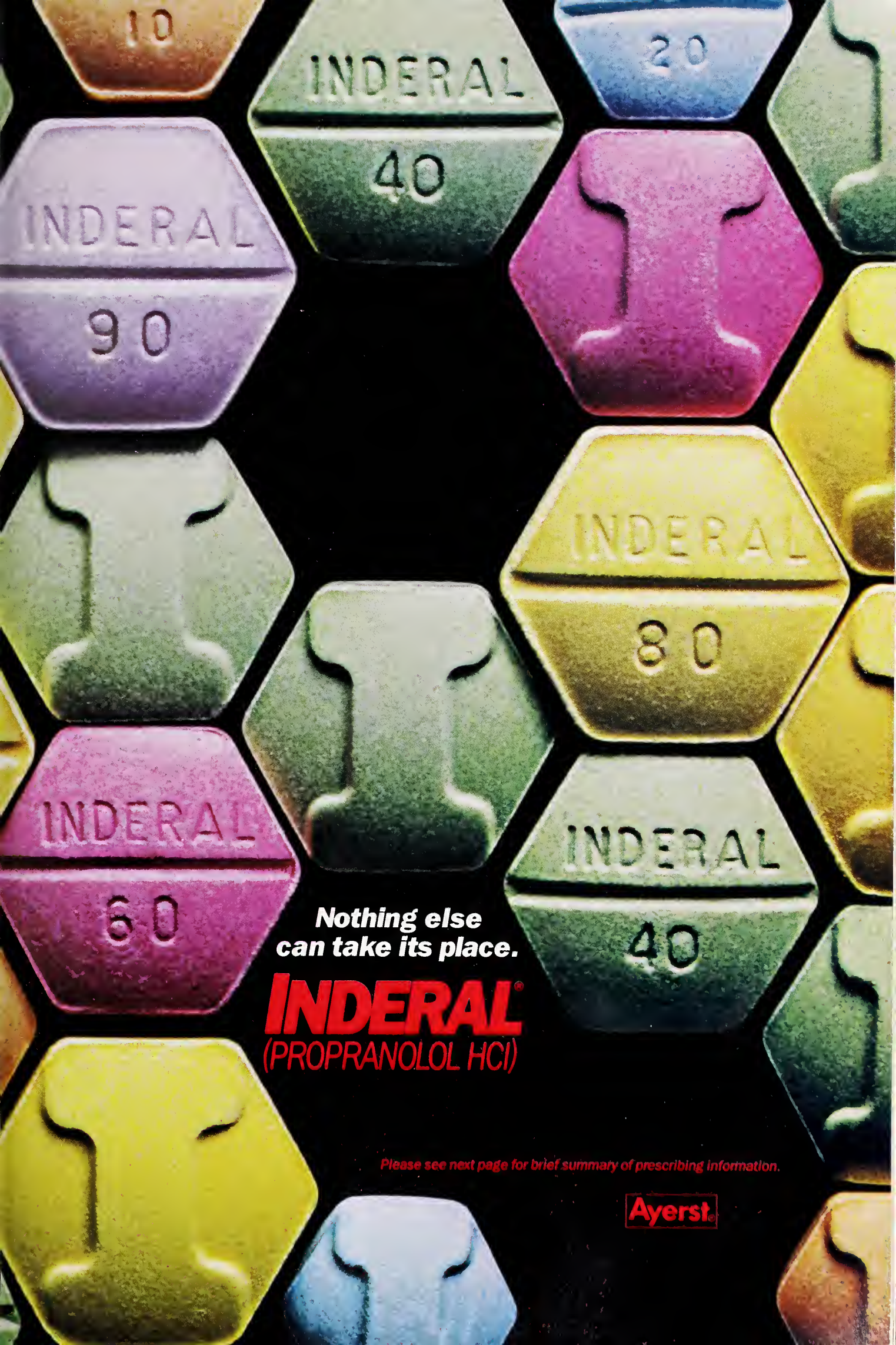
DR. COLBURN ELECTED TO NEW JERSEY GENERAL ASSEMBLY

Harold Colburn, Jr., M.D., a member of our Bur ington County component, the Board of Directors JEMPAC, and a Burlington County Freeholder w elected by an overwhelming margin to the Assembl Dr. Colburn will fill the Eighth District Assembly sea left vacant in July by the death of his Republican co league, Robert J. Meyer.

The September special election saw Dr. Colburn, dermatologist, defeat his Democratic rival, Phil Haines, by a three to two ratio, capturing 15 of th district's 23 towns. MSNJ's political action committe contributed several thousands of dollars to Dr. Co burn's campaign. Dr. Colburn, who will finish the r maining year of Meyer's term, will be the only phys cian in the state legislature.

FINI

"All the flowers of all the tomorrows are in the seed of today."



Nothing else can take its place.

INDERAL®
(PROPRANOLOL HCl)

Please see next page for brief summary of prescribing information.

Ayerst®

Nothing else can take its place.

INDERAL®
(PROPRANOLOL HCl)



10 mg 20 mg 40 mg 60 mg 80 mg 90 mg*

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

INDERAL® (propranolol hydrochloride) Tablets

CLINICAL PHARMACOLOGY

The Beta-Blocker Heart Attack Trial (BHAT) was a National Heart, Lung and Blood Institute-sponsored multicenter, randomized, double-blind placebo-controlled trial conducted in 31 U.S. centers (plus one in Canada) in 3,837 persons without history of severe congestive heart failure or presence of recent heart failure; certain conduction defects; angina since infarction, who had survived the acute phase of myocardial infarction. Propranolol was administered at either 60 or 80 mg t.i.d. based on blood levels achieved during an initial trial of 40 mg t.i.d. Therapy with INDERAL, begun 5-21 days following infarction, was shown to reduce overall mortality up to 39 months, the longest period of follow-up. This was primarily attributable to a reduction in cardiovascular mortality. The protective effect of INDERAL was consistent regardless of age, sex or site of infarction. Compared to placebo, total mortality was reduced 39% at 12 months and 26% over an average follow-up period of 25 months. The Norwegian Multicenter Trial in which propranolol was administered at 40 mg q.i.d. gave overall results which support the findings in the BHAT.

Although the clinical trials used either t.i.d. or q.i.d. dosing, clinical, pharmacologic and pharmacokinetic data provide a reasonable basis for concluding that b.i.d. dosing with propranolol should be adequate in the treatment of post-infarction patients.

CLINICAL: In the BHAT, patients on INDERAL were prescribed either 180 mg/day (82% of patients) or 240 mg/day (18% of patients). Patients were instructed to take the medication 3 times a day at mealtimes. This dosing schedule would result in an overnight dosing interval of 12 to 14 hours which is similar to the dosing interval for a b.i.d. regimen. In addition, blood samples were drawn at various times and analyzed for propranolol. When the patients were grouped into tertiles based on the blood levels observed and the mortality in the upper and lower tertiles were compared, there was no evidence that blood levels affected mortality.

PHARMACOLOGIC: Studies in normal volunteers have shown that a 90 mg b.i.d. regimen maintains beta blockade at, or above, the minimum for 60 mg t.i.d. dosing for 24 hours even though differences occurred at two time intervals. At 10-12 hours after the first dose of the day, t.i.d. dosing gave more beta blockade than b.i.d. dosing, at 20-24 hours the trend of the relationship was reversed. These relationships were similar in direction to those observed for plasma propranolol levels (see Pharmacokinetics).

PHARMACOKINETIC: A bioavailability study in normal volunteers showed that the blood levels produced by 180 mg/day given b.i.d. are below those provided by the same daily dosage given t.i.d. at 10-12 hours after the first dose of the day but above those of a t.i.d. regimen at 20-24 hours. However, the blood levels produced by b.i.d. dosing were always equivalent to or above the minimum for t.i.d. dosing throughout the 24 hours. In addition, the mean AUC on the fourth day for the b.i.d. regimen was about 17% greater than for the t.i.d. regimen (1,194 vs. 1,024 ng/ml• hr).

CONTRAINDICATIONS

INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS

CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS.

INDERAL (propranolol hydrochloride) should be administered with caution since it may b bronchodilation produced by endogenous and exogenous catecholamine stimulation of receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therap prior to major surgery is controversial. It should be noted, however, that the impaired abil the heart to respond to reflex adrenergic stimuli may augment the risks of general anest and surgical procedures.

INDERAL, like other beta blockers, is a competitive inhibitor of beta-receptor agonists its effects can be reversed by administration of such agents, e.g., dobutamine or isopro terenol. However, such patients may be subject to protracted severe hypotension. Difficu starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appea ance of certain premonitory signs and symptoms (pulse rate and pressure changes) of a hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more diffi to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Th fore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function te

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have bee reported in which, after propranolol, the tachycardia was replaced by a severe bradyca requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS

General: Propranolol should be used with caution in patients with impaired hepatic or re function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawa lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart dise elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as re pine should be closely observed if INDERAL is administered. The added catecholamine blocking action may produce an excessive reduction of resting sympathetic nervous a which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or ort static hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals h been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studi both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of sig cant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the age levels. Reproductive studies in animals did not show any impairment of fertility that attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL sh be used during pregnancy only if the potential benefit justifies the potential risk to the fe

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised w INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Most adverse effects have been mild and transient and have rarely required the withdra therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hyp sion; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insom lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; vi disturbances; hallucinations; an acute reversible syndrome characterized by disorient for time and place, short-term memory loss, emotional lability, slightly clouded sensoriu and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhe constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with a and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impo tence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reacti involving the skin, serous membranes and conjunctivae reported for a beta blocker (pr lol) have not been associated with propranolol.

*The appearance of INDERAL tablets is a registered trademark of Ayerst Laboratorie

8965/28

Ayerst® AYERST LABORATORIES
New York, N.Y. 10017

Malpractice: Two Points of View

Is the problem medical malpractice claims or medical malpractice? Attention needs to be focused on the incidence of actual malpractice.

Much attention has been given recently to allegations that soaring health care costs are the result of increasing medical malpractice suits. The facts demonstrate that this is not correct.

For example, in 1980, the total cost of health care in Pennsylvania was $10.7 billion; the total amount paid out in 1980 as a result of malpractice claims was a mere 4/10 of 1 percent of that figure.

Regarding the costs of malpractice insurance in Pennsylvania, the average physician spends 3.5 percent of his gross income on medical malpractice insurance, a tax-deductible business expense—exactly the national average. It is very likely that most motorists pay about as large a percentage of their gross incomes for automobile insurance that is not tax deductible. Of course, some physicians whose specialties involve especially high risks to patients pay higher percentages of their gross for medical malpractice insurance; however these specialists also enjoy net incomes substantially higher than the average physician.

Legislative efforts to reduce or eliminate needed compensation for the victims of medical malpractice will not cut costs. Someone will pay for the harm done. Such proposals simply would shift this heavy cost burden from the wrongdoer who caused it, onto the backs of the victims, their families, and the taxpaying public.

Instead of the wrongdoer paying for the harm out of liability insurance for medical malpractice or otherwise, the victim and the victim's family would pay out of their savings and other assets, including their health insurance (group and private), their sick leave, and disability insurance, and ultimately the taxpayer will pay in many cases through Medicare, Medicaid, medical assistance, and public assistance of all types.

Allegations of enormous costs attributable to so-called "defensive" medicine cannot be verified or substantiated. In fact, performing procedures solely to protect the doctor from a possible lawsuit without any medical need is not only unethical but also an assault and battery on the patient. "Defensive" medicine is nothing more than an emotional and pejorative term used by doctors to describe either the grudging practice of more careful medicine which means better, safer health care for patients, or a rationalization to excuse the profitable over-utilization of medical resources.

Further, the potential for liability prevents many deaths and countless serious injuries every year which would cost the health care system far more than the total cost of all malpractice claim payments.

Moreover, there is no justification for granting physicians special privileges and immunities not held by any other class of citizens. Doctors should be responsible for their conduct like anyone else.

Only 1 in 10 incidents of malpractice results in a claim being made. Less than half of these claims result in compensation from medical malpractice insurance. In fact, no more than 1 out of 25 incidents of malpractice result in the victim receiving compensation through malpractice insurance.

The problem is not medical malpractice claims, it is medical malpractice. Claims and litigation are merely the symptoms. Instead of focusing our efforts on shifting the cost of medical malpractice from the wrongdoer who caused the harm onto the backs of the victims and the taxpaying public, attention should be focused on reducing the incidence of actual malpractice. Such efforts not only would result in real savings, but would prevent much human misery.

The relatively small number of incompetent and impaired physicians who cause a disproportionate share of malpractice claims should be removed from the practice of medicine. According to Pennsylvania Medical Society statistics, at least 10 percent of physicians are impaired by drug or alcohol abuse at sometime in their careers.

According to recent testimony in front of the U.S. Senate Committee on Aging, chaired by Senator John Heinz (R., PA), Pennsylvania is one of fewer than ten states without a law requiring hospitals, peer review and professional organizations, insurance companies, and others who know the names of incompetent and impaired physicians to report those names to the State Licensing Board so that appropriate action can be taken.

Also needed is risk management legislation to identify frequently recurring types of malpractice in order to develop standardized training and procedures to prevent future instances of similar malpractice.

*This item from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are respectively, Director of the Department and Director of Special Projects.

The Pennsylvania Trial Lawyers Association is eager to work with other concerned organizations to help develop a comprehensive program for health care cost containment and quality assurance.

James F. Mundy
Chairman, Pennsylvania Trial Lawyers Association
Task Force on Health Care Cost
(*The Philadelphia Inquirer*, July 18, 1984)

REPLY: LAWSUITS RAISE HEALTH CARE COSTS

The article by James F. Mundy, "Malpractice Suits: A Medical Problem," included a number of statements that are subject to question.

The first of these is that increasing numbers of medical malpractice suits are not a factor in soaring health care costs and that the cost of malpractice insurance is proportionately no greater than what most car owners pay for insurance.

While Mr. Mundy quotes an average national figure of 3.5 percent of a physician's gross income as the cost of medical liability insurance, that figure, even if accepted as accurate, does not reflect the true one of many physicians in the Philadelphia area who are practicing the more complicated and risk-associated specialties, such as general surgery and surgical specialties.

A more realistic figure for this group is 15 percent to 20 percent of gross income, such gross income being well below what many people may believe these physicians earn. There are many surgical specialists who may be grossing $100,000 and who are paying $33,000 or more, in addition to all other expenses necessary to maintain a practice.

Mr. Mundy is in error when he states that "defensive medicine" is illusory and does not play a part in the increasing cost of medical care. Testimony before the House Ways and Means Committee on June 28 set the cost of defensive medicine at $15 billion or more a year, and these are only incurred to protect the physician from allegations of malpractice when a medical result is less than optimal. These defensive-measure figures are real, not imagined.

Mr. Mundy suggests that getting rid of the incomp tent physicians would solve the problem, suggestir that there would be very few malpractice claims. Tl incompetent physician is generally not the one again whom claims are made. Most claims are against tl leaders in the medical community, those to whom ar physician would gladly go if he himself needed medi care.

Errors in medical care do occur, and when a patie is harmed there should be adequate compensatio This is why the physicians carry professional liabili insurance.

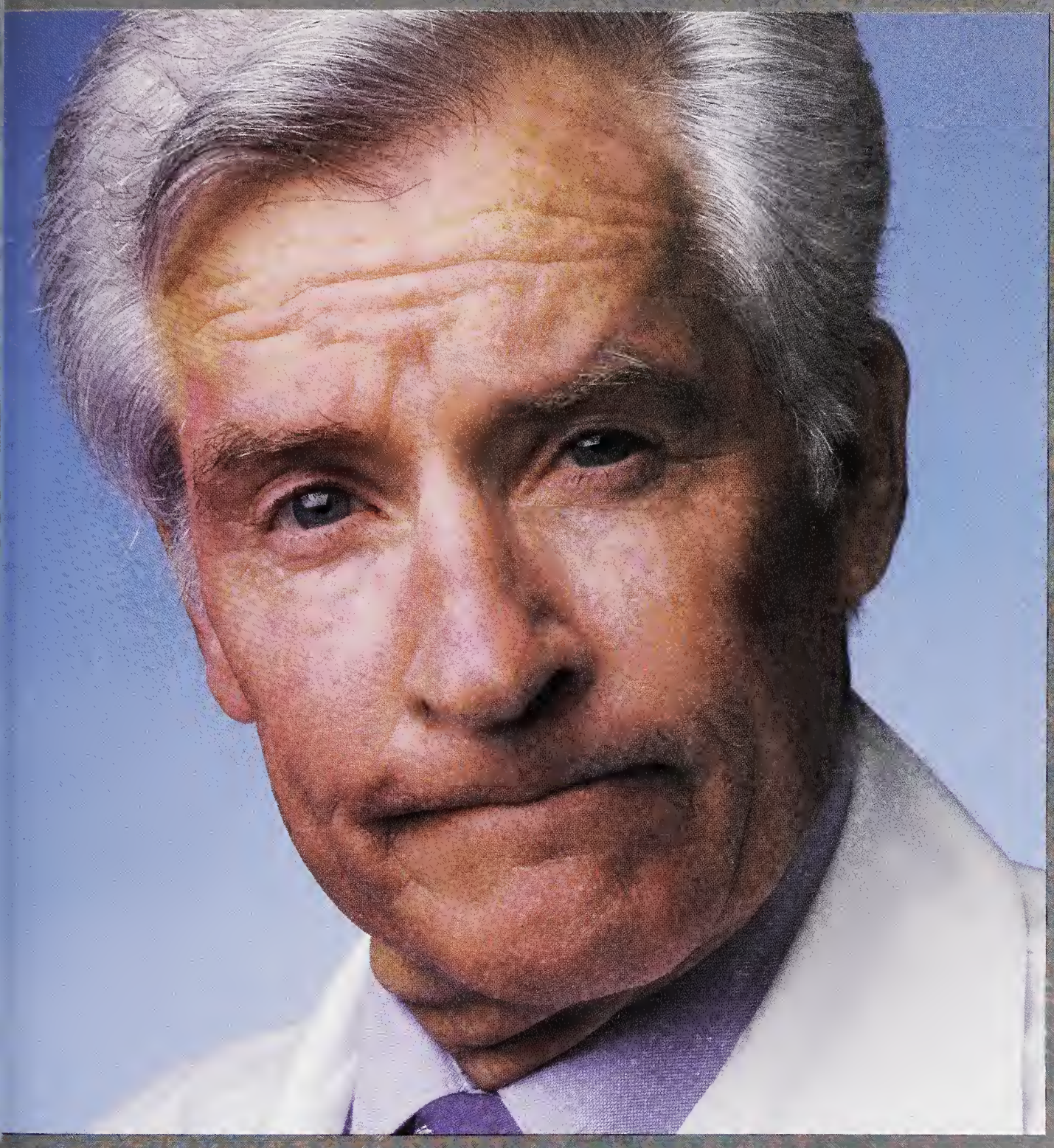
However, while the aggregate insurance fund s aside is more than adequate, less than 35 perce reaches the injured parties. The remainder is gobbl up by the cost of litigation, the beneficiaries being t plaintiff, and defense bars.

If the plaintiff's bar is truly concerned with the w fare of their clients, why is it so opposed to a limit the fees that they would be paid? The schedu proposed by the Medical Society adequately would imburse a lawyer for his efforts, without allowing hi a windfall. At present, in may cases, the patient's la yer receives much more than his client. The insuran fund has not been set up as "slush" fund for lawye

Jerry Zaslow, M.D., J
Preside
Philadelphia County Medical Socie
(*The Philadelphia Inquirer*, August 8, 198

FOOTNOTE

The problem of outsized awards in medical malpra tice cases appears to be getting worse, according to study by the Insurance Information Institute. La year, judgments against physicians and hospitals California totaled $31.8 million, compared with $1 million the previous year. And the average award $649,210 was more than twice 1982's figure $257,222. On the other hand, the number of verdi in the plaintiff's favor dropped 18 percent. (*Medi Economics*, July 23, 1984)



SO HOW COME YOU'RE STILL WORRIED?

u know they mean well. But you also need to know that many alpractice insurers simply don't have The St. Paul's financial bility. Assets over $5.3 billion. Expertise measured by more than 0 years in the insurance business. Commitment best exemplified nearly 50 years of providing insurance to the medical community.

ore than 55,000 physicians, over 1,550 hospitals and hundreds thousands of other health care professionals already insure th The St. Paul. They benefit from loss prevention programs that work, claims service that is second to none and the peace of mind that only St. Paul's experienced staff and financial resources can provide.

Call Tim Morse, senior marketing officer in The St. Paul's Medical Services Division. His toll free phone number is 1-800-328-2189, extension 7642. He'll explain our approach and put you in touch with an independent insurance agent who understands your needs.

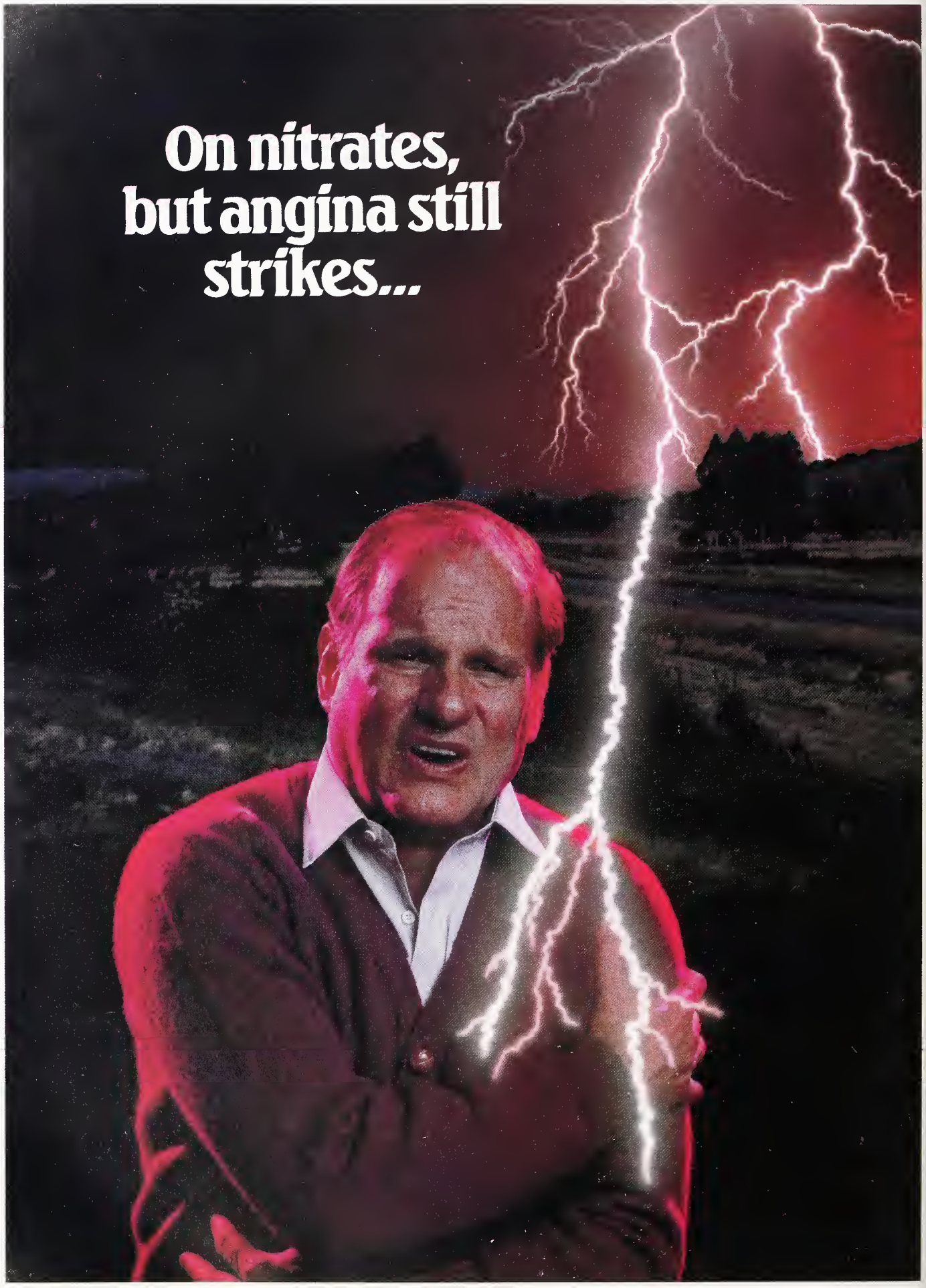
WORRY-FREE INSURANCE FROM The St.Paul

Medical Services Division

IA

YOUR Independent Insurance AGENT

St. Paul Fire and Marine Insurance Company/St. Paul Mercury Insurance Company/The St. Paul Insurance Company/St. Paul Guardian Insurance Company/The St. Paul Insurance Company of Illinois. Property and Liability Affiliation of The St. Paul Companies Inc., Saint Paul, Minnesota 55102.


On nitrates,
but angina still
strikes...

After a nitrate, add ISOPTIN®
(verapamil HCl/Knoll)

To protect your patients, as well as their quality of life, add Isoptin instead of a beta blocker.

First, Isoptin not only reduces myocardial oxygen demand by reducing peripheral resistance, but also increases coronary perfusion by preventing coronary vasospasm and dilating coronary arteries — both normal and stenotic. These are antianginal actions that no beta blocker can provide.

Second, Isoptin spares patients the beta-blocker side effects that may compromise the quality of life.

With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin...for more comprehensive antianginal protection without side effects which may cramp an active life style.



ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page.

ISOPTIN® TABLETS
(verapamil HCl/Knoll)
80 mg and 120 mg

Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction <30%) or moderate to severe symptoms of cardiac failure. Control milder heart failure with optimum digitalization and/or diuretics before ISOPTIN is used. ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild, and controlled by decrease in ISOPTIN dose). Occasional elevations of liver enzymes have been reported; patients receiving ISOPTIN should have liver enzymes monitored periodically. Patients with atrial flutter/fibrillation and an accessory AV pathway (e.g., W-P-W or L-G-L syndromes) may develop a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion. AV block may occur (3rd degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema, and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with ISOPTIN. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, patients should be monitored closely. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function or in patients who have also recently received methyldopa. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patient carefully monitored. ISOPTIN may have an additive hypotensive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR<50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%). The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: confusion, paresthesia, insomnia, somnolence, equilibrium disorders, blurred vision, syncope, muscle cramps, shakiness, claudication, hair loss, maculae, and spotty menstruation. Overall continuation rate of 94.5% in 1,166 patients. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in 80 mg and 120 mg sugar-coated tablets. July 1982 2068

KNOLL PHARMACEUTICAL COMPANY
Knoll® 30 NORTH JEFFERSON ROAD, WHIPPANY, NEW JERSEY 07981

2195

My Patients Were Fine... My Practice Was Ailing!



My Remedy: EXECU-FLOW SYSTEMS... "A Good Shot In The Arm!"



Computers are revolutionizing the practice of medicine. Execu-Flow Systems is at the forefront of this revolution, providing you with the latest in software/hardware technology.

You can start with Patient Billing and Insurance Processing, and add other systems such as Appointment Scheduling, Medical Records, Electronic Claims, Word Processing, etc.

Our many years of experience with practices such as yours, **GUARANTEES** our mutual success. Our system provides you with the peace-of-mind in knowing that your practice is operating at peak efficiency.

Could *your practice* use a *"Shot in the Arm?"*

- **Multi-tasking** IBM XT/IBM 9000/ CONTEL CADO Systems
- Software for *YOUR SPECIALTY*
- Automatic Prescription System
- Complete "Paperless" Office Available
- Comprehensive Patient Recall System

EXECU-FLOW SYSTEMS INC.

2013 Morris Avenue, Union, N.J. 07083
or call (201) 851-0750

I Did Not Sign

I did not sign the Medicare contract concerning the fee freeze and I have no intention to do so.

Like all physicians, I received a Medicare contract. I read it carefully, but I did not sign and have no intention to do so.

I have many patients who have a card entitling them to have health care services reimbursed by the federal government to which they have paid taxes for many years. They are not Medicare patients; they are people who have an insurance card! Among them are individuals who are barely surviving economically, some who are millionaires, and many who are very comfortable financially.

The Medicare contract and the law (the Deficit Reduction Act of 1984, P.L. 98-369), on which the contract was based, contains some promises and some threats. I made a careful analysis of my practice and concluded that the fee freeze followed by P.O. 98-369 will reduce my practice income from 30 to 50 percent, and will necessitate a marked reduction of my office staff (registered nurse, insurance clerk-bookkeeper, receptionist, part-time physician, and part-time dietitian). I also concluded that I could not function on a 60- to 80-hour week with less help and such a drastic reduction in practice income.

Aside from the above, I did not sign as a matter of principle:

1. The law is unfair and discriminatory. There is no profession in America whose salaries and income are frozen. The President, House of Representatives, and Senate have not frozen their salaries, despite the fact that many of them are millionaires. Government employees have not had their wages frozen. The lawyers who negotiated a $180 million settlement for alleged victims of the herbicide Agent Orange asked for up to $26 million in legal fees.

2. I do not advertise. Being old-fashioned, I feel it lowers my profession to advertise in newspapers and other media. The privilege of having my name on a "participating physicians" list is no carrot and having my name on a "nonparticipating physicians" list is no threat.

3. The law is a threat to patients' freedom of choice. My patients select me as their physician and keep me as their physician because they choose to do so. If I meet their needs, they stay with me. If I do not, they select another physician.

4. They are wrong again—the government planners were wrong when they estimated the cost of Medicare and Medicaid. They will be wrong again for the "savings" will be an atom in the bucket known as the national deficit.

Each of us has to make his or her own decision. I applaud the AMA for initiating a lawsuit against Margaret Heckler, Secretary of the Department of Health and Human Services. The complaint argues that the law violates the rights of Medicare beneficiaries and of physicians in several ways:

1. It is possible that patients would lose their right (granted by the Medicare law) to choose the physician because that physician would be economically unable to continue caring for them for the amount of money to be paid by Medicare.

2. At the end of the freeze period, Medicare's 80 percent of an approved amount will be less for patients of nonparticipating physicians for the same services. This is a violation of the Medicare law and of the Fifth Amendment.

3. The freeze, which prohibits nonparticipating physicians from increasing their charges to Medicare patients—even when those patients are able and perfectly willing to pay more—forbids physicians from freely making contracts with patients. Such restrictions do not exist against any other part of our society, or against any other element of the economy.

I intend to treat my patients, who are recipients of Medicare benefits and who select me as their physician, to the best of my ability. Like all physicians, I will accept the insurance payment for those who cannot afford to pay my usual fee. I expect most New Jersey physicians will do the same.

It seems obvious to me that this is the moment for American physicians to take a strong stand together. As Harry Schwartz, Ph.D., the nationally known journalist, editor, and critic, said, "The American Medical Association is the only game in town," when it comes to protecting physicians' rights. A.K.

"A MIDLANTIC CREDIT LINE CAN PUT $100,000 RIGHT AT YOUR FINGERTIPS."

"Investments. Auctions. College. Business expansion.

"Will you have ready capital when golden opportunities knock? The Hungry Bankers say 'Yes.'

"We give you a choice of credit lines that put you in touch with a whole world of financial freedom.

"Chec-King, for instance, adds the convenience of a line of credit to your Midlantic checking or NOW account. Whenever you need money, write a check —up to the limit of your credit line.

"Need a larger line of credit? Try our Capital Line[sm] account on for size. It gives you a standing line of credit. Anywhere from $10,000 to $100,000.

"Any time a great opportunity comes your way, simply write one of your Capital Line checks. As often as you like. For as little as $500. Or as much as $100,000.

"Applying is easy, too. Just stop by any Midlantic office. Our brief application could be the last of its kind you'll ever have to fill out.

"Let the Hungry Bankers put up to $100,000 of financial leverage right at your fingertips.

"Then, when you need it, you've got it."

FOOD FOR THOUGHT FROM THE HUNGRY BANKERS

MIDLANTIC



Bob Van Buren, Chairman, Midlantic Banks Inc.

Member
Equal Opportunity Lender

Fiduciary Responsibility

VINCENT A. MARESSA, J.D.

Members of a hospital governing board are fiduciaries of the hospital corporation. This relationship is a special one—ethically and legally.

Members of a hospital governing board are fiduciaries of the hospital corporation, and of the shareholders or members of the corporation. This relationship is a special one, both ethically and legally. It means that the interests of the individual must be subordinated to that of the institution. Board members may not take secret profits from the hospital or compete with it. Board members must exercise reasonable care, skill, and diligence in the discharge of their duties.

The requirements of proper fiduciary conduct present serious questions for physicians and lay members serving on hospital governing boards. There is no per se rule that one cannot render this service objectively and to the full benefit of the hospital corporation while advancing his own interests. It does mean, however, that physicians who serve on a governing board should not structure their private practices to have a substantial adverse impact on the hospital's operation. Businessmen on the board may contract with the hospital. Those contracts, however, should be at arm's-length and carefully reviewed to assure absolute fairness to the hospital. Attorneys serving as board members should not be acting as legal counsel to the board or to the hospital administration. Their representation of either should be only on a limited and ad hoc basis, which has undergone careful scrutiny.

Post, Peters, and Stahl point out in their recent publication, *The Laws of Medical Practice in Pennsylvania and New Jersey,* that according to the Pennsylvania administrative code, members of a governing body may not maintain substantial, personal, or business interests, which conflict with those of the hospital. All such members must execute a conflict of interest statement. The code further proscribes certain forms of self-dealing.

In New Jersey, we do not have specific statutory or regulatory laws on this topic. Our case law declares simply that a fiduciary duty exists not only to the hospital, but to the general public it serves. Breach of this duty can lead to personal liability for acts carried out in the name of the hospital.

Every governing body should request its legal counsel to present an opinion and discussion of applicable conflict of interest and fiduciary law and conduct so that governing board members may properly serve the hospital entity.

*The material for this column is coedited by Arthur Krosnick, M.D., Editor, *The Journal,* MSNJ; Vincent A. Maressa, J.D., Executive Director, MSNJ; and James E. George, M.D., J.D., Director of Professional Liability, MSNJ.

DOCUMENTED IN THE SLEEP LABORATORY[1-5]...



ONLY DALMANE (flurazepam HCl/Roche PROVIDES ALL THESE BENEFIT FOR RESTFUL SLEEP

- Rapid sleep onset[1]
- More total time asleep[1]
- Undiminished efficacy for at leas 28 consecutive nights[2]
- Patients usually awake rested an refreshed[7]
- Avoids causing early awakenings c rebound insomnia after discontinuation[2,5,10-

Copyright © 1984 by Roche Products Inc. All rights reserved.


PROVEN IN
THE PATIENT'S HOME
BECAUSE THERE IS NO SUBSTITUTE
FOR EXPERIENCE
DALMANE®
flurazepam HCl/Roche
STANDS APART
15-MG/30-MG CAPSULES
DALMANE® 30 ROCHE
DALMANE® 15 ROCHE
Caution patients about driving, operating hazardous machinery or drinking alcohol during therapy. Limit dose to 15 mg in elderly or debilitated patients. Contraindicated during pregnancy.
See next page for references and summary of product information.
ROCHE

DALMANE®
flurazepam HCl/Roche

References: **1.** Kales J *et al: Clin Pharmacol Ther* 12:691-697, Jul-Aug 1971. **2.** Kales A *et al: Clin Pharmacol Ther* 18:356-363, Sep 1975. **3.** Kales A *et al: Clin Pharmacol Ther* 19:576-583, May 1976. **4.** Kales A *et al: Clin Pharmacol Ther* 32:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol* 3:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther* 21:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. **9.** Amrein R *et al: Drugs Exp Clin Res* 9(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol* 3:303-326, May 1981. **11.** Greenblatt DJ *et al: Sleep* 5(Suppl 1):S18-S27, 1982. **12.** Kales A *et al: Pharmacology* 26:121-137, 1983.

DALMANE® ®
flurazepam HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage, 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE Roche Products Inc.
Manati, Puerto Rico 00701

MEDICAL COMPUTERS

DEC - IBM - TELEVIDEO
ALTOS - NCR

THINKING OF COMPUTERIZING YOUR PRACTICE?

FBL MEDICAL COMPUTER SPECIALISTS offers a wide variety of hardware/software configurations for every medical office, hospital and clinic application.

- AUTOMATIC INSURANCE FORM PREPARATION
- ACCOUNTS RECEIVABLE CONTROL
- AUTOMATIC PATIENT RECALL
- PRACTICE MANAGEMENT REPORTS
- CLINICAL RECORDS
- ACCOUNTS PAYABLE
- APPOINTMENT SCHEDULING
- ELECTRONIC CLAIMS SUBMISSION
- WORD PROCESSING
- MEDICARE/MEDICAID BILLING
- GENERAL LEDGER
- INVENTORY

UNIX SOFTWARE AVAILABLE FOR ALTOS AND NCR
MUMPS SOFTWARE AVAILABLE FOR DEC

SPECIALISTS IN MULTI-USER, MULTI-TASKING
DATA-BASE MANAGEMENT SYSTEMS.

FBL

PROVIDING YOU WITH OVER 15 YEARS OF MEDICAL COMPUTER EXPERIENCE

CONSULTING SERVICE AVAILABLE

3 ROUTE 46W, FAIRFIELD, N.J. 07006 201-882-9210

TAX SHELTERS

Just one of the personal financial services available to you from the ***physician's bank.***

- tax planning
- lines of credit
- equipment financing
- retirement planning

- money management
- cash flow • investments
- estate planning

Call or Write
Joseph J. Verbaro, Jr.
Senior Vice President
(201) 228-9770

FINTRUST
FINANCIAL AND TRUST SERVICES
DIVISION OF SECURITY NATIONAL BANK & TRUST COMPANY OF NEW JERSEY
101 Eisenhower Parkway
Roseland, New Jersey 07068 Member F.D.I.C.

Maternal Deaths In New Jersey—1982*

Gerard F. Hansen, M.D., M.P.H., Newark**
Margaret Gregory, M.D., F.A.A.P., Trenton**

Twenty-four deaths of pregnant women were reported in New Jersey in 1982. Obstetrical hemorrhage was a factor in three of the nine potentially preventable deaths. Complications following postpartum sterilization were associated with six maternal deaths.

The Subcommittee on Maternal Mortality, a subdivision of the Committee of Maternal and Infant Welfare, is charged with investigating all maternal deaths in New Jersey on a yearly basis. This task is accomplished with the help and cooperation of the Maternal and Child Health Program of the State Department of Health. Health care facilities are required to report maternal deaths and to forward to the State Department of Health a copy of the available records. Materials then are forwarded to the chairperson of the subcommittee for review. The chairperson assigns each case or cases to a member of the subcommittee. The committee member prepares a brief outline of each case and it is presented at the annual meeting of the subcommittee. A consensus regarding preventability is reached and a report is issued and published in *The Journal*. The focus of the article is educational and serves to point out areas of care that can be improved.

RESULTS

There were 94,965 live births in New Jersey in 1982; 24 deaths of pregnant women were reported and presented to the committee for evaluation.[1] This is an increase over the 18 deaths reported in 1981,[2] but this may be due to increased surveillance and a question on the revised death certificate which asks if the person was pregnant at the time of death.

Abdominal delivery, multiparity, and being nonwhite, continue to be factors that increase the risk of maternal death. Prenatal care was deemed adequate in only 46 percent of the cases. Six of the 20 maternal deaths did not have a postmortem examination.

A maternal death is defined as the death of a woman within 90 days of termination of pregnancy regardless of duration or site of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.[3] The World Health Organization (WHO) uses 42 days of termination of pregnancy in its statistics. New Jersey currently uses the WHO definition.

A nonmaternal death is the death of a woman who was pregnant but whose demise was not relative to the pregnancy or its management. A bombing, an auto accident, a fire, and a drug overdose each caused one nonmaternal death. Such catastrophes remind us that

*This article is the result of the work of the members of the Subcommittee on Maternal Mortality and the State Department of Health: James P. Thompson, M.D., Chairman; Jerald R. Cureton, M.D.; Joseph DeStefano, M.D.; Eugene M. Graziano, M.D.; Margaret Gregory, M.D.; William Hartko, M.D.; Michael Kreitzer, M.D.; Robert Malatesta, M.D.; Thomas A. Noone, M.D.; Joseph Saladino, M.D.; and Leah Ziskin, M.D.

**Dr. Hansen is Associate Professor of Clinical Obstetrics and Gynecology and Director of the Obstetrical and Gynecology Clinic at the UMDNJ-New Jersey Medical School. Dr. Gregory is Coordinator, Maternal and Child Health Program New Jersey State Department of Health. Correspondence may be addressed to the Department of Ob-Gyn, UMDNJ-New Jersey Medical School, 100 Bergen Street, Newark, NJ 07103.

TABLE 1

Classification and Mortality Rates

Live Births*	94,965
Maternal Deaths	24
Nonmaternal	4
Indirect	8
Direct	12
Rate (indirect only)	8.4/100,000 live births
Rate (direct only)	12.6/100,000 live births
Rate (all causes)	21.0/100,000 live births

*Live births are events in New Jersey hospitals. Total births to New Jersey residents in 1983 exceeded this total because some women delivered out of state.

TABLE 2

*Characteristics of Maternal Deaths by Race, Age, and Prenatal Care**

	Number	Percent
Race		
White	8	40
Other	12	60
Age		
Less than 20	1	5
20 to 34	13	65
35 to 39	3	15
Greater than 40	3	15
Prenatal Care		
None	2	10
Inadequate	1	5
Unknown	8	40
Adequate	8	40
Excluded (ectopic)	1	5

*Nonmaternal deaths excluded

accidental injuries too often occur to pregnant women. Drugs still remain a problem in our society as evidenced by one death of a pregnant woman. The above deaths should be preventable and were due to conditions in our society that must be addressed.

An indirect maternal death is the death of a pregnant woman resulting from previously existing disease or a disease that develops during pregnancy, labor, or the puerperium which is not directly due to obstetrical causes, but is aggravated by the physiological effects of pregnancy. There were eight such deaths, six of which were felt to be nonpreventable by our present medical standards of care.

A potentially preventable death was due to cardiomegaly in a patient who died one day after a postpartum sterilization. The patient had a history of alcohol and drug abuse and should have been evaluated medically before an elective procedure such as a tubal ligation was performed. A second patient died of paralytic ileus following a postpartum sterilization. It was felt that too little attention was paid to the patient postoperatively.

Three of the six indirect nonpreventable deaths were due to diseases of the heart (rheumatic heart disease, aortic valve disease, and cardiomyopathy). One case of gangrene of the small bowel following repeat cesarean section with tubal ligation was felt to be nonpreventable. The deaths of one patient with cystic fibrosis a another with a rare hemolytic anemia were judg nonpreventable by present day standards of care.

A direct maternal death is the death of a pregna woman usually from complications of the pregnan labor, puerperium, intercessions, omissions, incorr treatment, or a chain of events resulting from any these complications.

Two cases of amniotic fluid embolus were found be nonpreventable as in each case there had been preceding event (such as injudicious use of Pitoci that could have contributed to the events. An autop in one instance established the cause of death to ha been amniotic fluid embolism and not eclampsia was diagnosed clinically. The value of postmort examination in this case is obvious. A patient witl ruptured ectopic pregnancy was dead on arrival a hospital; she had not sought prenatal care.

Of the eight direct maternal deaths that were felt be potentially preventable, three deaths were due postpartum hemorrhage. In two of these cases, plac ta previa and cesarean section were involved and th was a failure to adequately and quickly replace blo loss resulting in shock and development of coagulati disorders. The third patient died as a result of hem rhage due to a ruptured uterus when an internal v sion for a dead infant was attempted. In this instan the woman was obese and presented herself at t hospital with a history of contractions for one day fetal arm had prolapsed through the cervix. Becau of the obesity, a version was attempted and the ute

TABLE 3

Parity and Duration of Pregnancy

Parity	Number	Percent
0	2	10
1 to 3	14	70
4 to 6	3	15
Unknown	1	5
Gestational Age		
Less than 20 weeks	2	10
20 to 28	3	15
28 to 40	8	40
Over 40	6	30
Unknown	1	5

TABLE 4

Classification and Preventability

Nonmaternal			4
Maternal			20
Indirect		8	
Nonpreventable	6		
Preventable	2		
Direct		12	
Nonpreventable	4		
Preventable	8		
Physician factor		8	
Patient factor		1*	

*In one death physician and patient shared preventabili

TABLE 5

Causes of Death

		No.	Total
I.	Nonmaternal		4
	Auto accident	1	
	Bombing	1	
	Drug overdose	1	
	Fire	1	
II.	Maternal		
	A. Indirect		8
	1. Nonpreventable		
	Hemolytic anemia	1	
	Rheumatic heart disease	1	
	Cystic fibrosis	1	
	Gangrene of the small bowel	1	
	Aortic valve disease	1	
	Subarachnoid hemorrhage	1	
	2. Preventable		
	Paralytic ileus post-tubal litigation	1	
	Cardiac failure associated with tubal ligation	1	
	B. Direct		12
	1. Nonpreventable		
	Amniotic fluid embolus	2	
	Ruptured ectopic pregnancy	1	
	2. Preventable		
	Amniotic fluid embolus	1	
	Anesthesia	1	
	Postpartum hemorrhage	3	
	Self-induced abortion	1	
	Adult respiratory distress syndrome secondary to sepsis	1	
	Septic pulmonary embolus after postpartum tubal ligation	1	
	Ileus secondary to torsion of greater omentum	1	

TABLE 6

Preventability of Maternal Deaths

A.	Indirect Causes		8
	Nonpreventable	6	
	Preventable	2	
B.	Direct Causes		12
	Nonpreventable	4	
	Preventable	8	
	1. Physician factor	8	
	2. Patient factor	1*	

*One death had physician and patient factor

ptured. A pathologic retraction ring was found at topsy. While cesarean section on a 270-pound man with a dead baby would be difficult and frus- ting, the attempted version was ill advised.

One patient died of a septic pulmonary embolus two eks after postpartum tubal ligation. Another patient d five days after sterilization due to ileus secondary torsion of the greater omentum. These cases remind that sterilization of the female is not an innocuous ocedure and such patients must be monitored as efully after surgery as any patient undergoing ab- minal surgery.

A case of amniotic fluid embolism was felt to be ventable because a tear in the anterior lower uterine segment was not diagnosed prior to post-mortem examination. A patient in the hospital with a history of ruptured membranes at 20 weeks' gestation, not confirmed, attempted a self-abortion with a clothes hanger. Autopsy revealed a lower segment uterine laceration with a pneumocardium of 300 cc of air in the right side of the heart. An awareness of the desperation of this woman might have prevented this tragedy. It is important to remember that this type of situation might recur if abortions once more are made illegal.

One patient had cardiac failure secondary to inability to successfully intubate the patient for anesthesia prior to tubal ligation. It was felt that the procedure should have been postponed if optimal anesthesia could not be safely obtained.

A diabetic patient 20 days after cesarean section was readmitted because of mechanical small bowel obstruction secondary to a pelvic abscess. She previously had a paralytic ileus following delivery. Failure to see the patient sooner after discharge from the hospital was felt to be a factor in her demise.

RECOMMENDATIONS

Since the purpose of the review of maternal deaths is educational, the following observations are presented:

1. The presence of cardiac problems should be determined by careful history and physical evaluation. The first physician who sees an adult female may be the physician who will deliver her infant. The initial examination may disclose a previously undiagnosed cardiac defect that must be followed closely. This recommendation applies to all pre-existing conditions which diligently should be searched for as they influence the number of maternal deaths.

2. Postpartum tubal ligation is an operation that has all the risks of any abdominal procedure. As it is an elective operation, surgery can and should be postponed if the patient has any problem or condition that merits evaluation before the procedure is performed. The patient should receive the same careful po operative care as she would have received for a laparotomy. It should be noted that six mater deaths were associated with a sterilization procedu

3. Careful outpatient followup of all surgical tients, especially diabetics, is essential.

REFERENCES

1. New Jersey State Department of Health: Maternal Child Health Program, Program Report. Trenton, NJ, 19

2. Hansen GF, Gregory M: Maternal deaths in New sey—1981. *J Med Soc NJ* 80:261-263, 1983.

3. Braunn AW, Cefalo RC (eds): *Guidelines for Perin Care*. 202-203, 1983.

BALANCED CALCIUM CHANNEL BLOCKADE!



Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

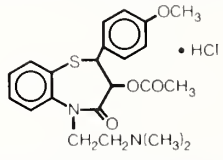
Please see full prescribing information on following page.

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), ras asthenia (1.2%), AV block (1.1%). In addition, the followi were reported infrequently (less than 1%) with the order of tion corresponding to the relative frequency of occurrenc

Cardiovascular:	Flushing, arrhythmia, hypotension, dia, palpitations, congestive hea syncope.
Nervous System:	Paresthesia, nervousness, som tremor, insomnia, hallucinations, and
Gastrointestinal:	Constipation, dyspepsia, diarrhea, mild elevations of alkaline phosphata SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photos
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing ep vasospastic angina developed periods of transient asyr asystole approximately five hours after receiving a sin dose of CARDIZEM.

The following postmarketing events have been repo quently in patients receiving CARDIZEM: erythema multif kopenia; and extreme elevations of alkaline phosphata SGPT, LDH, and CPK. However, a definitive cause and effec these events and CARDIZEM therapy is yet to be establi

OVERDOSAGE OR EXAGGERATED RESPON

Overdosage experience with oral diltiazem has bee Single oral doses of 300 mg of CARDIZEM have been wel by healthy volunteers. In the event of overdosage or ex response, appropriate supportive measures should be en addition to gastric lavage. The following measures may be c

Bradycardia	Administer atropine (0.60 to 1.0 m is no response to vagal blockade, isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. F degree AV block should be treated diac pacing.
Cardiac Failure	Administer inotropic agents (isop dopamine, or dobutamine) and diure
Hypotension	Vasopressors (eg, dopamine or le bitartrate).

Actual treatment and dosage should depend on the sev clinical situation and the judgment and experience of th physician.

The oral/LD_{50}'s in mice and rats range from 415 to 7 and from 560 to 810 mg/kg, respectively. The intravenou these species were 60 and 38 mg/kg, respectively. The o dogs is considered to be in excess of 50 mg/kg, while let seen in monkeys at 360 mg/kg. The toxic dose in man is r but blood levels in excess of 800 ng/ml have not been a with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclero nary Artery Disease or Angina Pectoris at Rest Du nary Artery Spasm. Dosage must be adjusted to each needs. Starting with 30 mg four times daily, before me bedtime, dosage should be increased gradually (given doses three or four times daily) at one- to two-day inte optimum response is obtained. Although individual pat respond to any dosage level, the average optimum dos appears to be 180 to 240 mg/day. There are no available da ing dosage requirements in patients with impaired renal function. If the drug must be used in such patients, titration carried out with particular caution.

Concomitant Use With Other Antianginal Agents

1. **Sublingual NTG** may be taken as required to a anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may coadministered with short- and long-acting nitrates have been no controlled studies to evaluate the effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTION

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 0088-1771-47) and in Unit Dose Identification Paks of 0088-1771-49). Each green tablet is engraved with MARI side and 1771 engraved on the other. CARDIZEM 60- tablets are supplied in bottles of 100 (NDC 0088-1772-47) Dose Identification Paks of 100 (NDC 0088-1772-49). E tablet is engraved with MARION on one side and 1772 o

Issu

Another patient benefit product from

PHARMACEUTICAL DIVISION
MARION LABORATORIES, INC.
KANSAS CITY, MISSOURI 64137

Ceftriaxone, a Third Generation Cephalosporin

Edward S. Johnson, M.D., Marc Fedder, M.D., Leon G. Smith, M.D., Newark*

Ceftriaxone is a new third generation cephalosporin with an unusually prolonged half-life and broad antibacterial spectrum. These properties decrease length of hospital stay. Our studies show ceftriaxone as a safe and effective antibiotic for serious bacterial infections.

Ceftriaxone, a new third generation cephalosporin, has good activity against gram-positive l gram-negative bacteria and has increased stability inst various types of beta-lactamases.[1] Ceftriaxone a prolonged serum half-life of 6.5 h to 8.6 h and drug can be given at longer time intervals than st other conventional antibiotics.[2] Ceftriaxone penates into the cerebrospinal and intestinal fluids dily and the elimination from these compartments slower than other related B-lactam antibiotics.[3]

TERIALS AND METHODS

eftriaxone was used to treat 46 patients and of se, 38 patients met the clinical criteria for evaluon in this study. The 8 patients who were excluded n the study included 5 patients with no bacterial hogen isolated, and 3 patients who signed out of hospital against medical advice.

ll of the patients in this study were treated as inpaits at Saint Michael's Medical Center, Newark. Paits were selected on the basis of documented infecns or suspected bacterial infections after being luated by the infectious diseases staff. All of the ients were 18 years or older and written consent s obtained from all of the patients. Cultures were ained prior to starting patients on ceftriaxone ther. A culture was repeated usually 48 hours after ting therapy and where clinically indicated or feasible at the end of therapy. A bacterial organism was isolated on all patients in the group that was evaluated.

Ceftriaxone (Ro 13-9904) is a 2-aminothiazolyl methoxyimino cephalosporin derivative.[4] The drug was obtained from Hoffmann-La Roche, Inc., and was in the form of a crystalline powder. The drug was administered every 12 or 24 hours either intramuscularly or intravenously. The drug was diluted with water and mixed with 50 cc of D5W or 50 cc of normal saline for intravenous use. For intramuscular use, the drug was mixed with 1 percent lidocaine hydrochloride solution. Lidocaine was used in place of sterile water to minimize discomfort of the intramuscular injection. Many of the patients with osteomyelitis were treated as outpatients after initial evaluation and treatment as inpatients. A daily intramuscular injection was given for these patients. The bacterial isolate susceptibility of ceftriaxone was determined by standardized Kirby-Bauer technique. The minimal inhibitory concentrations for all isolates were determined by the microliter technique (Dynatech). Trypticase Soy broth was used with an inoculum of culture containing 10^5 colony-forming units per ml of an overnight broth.

Osteomyelitis was diagnosed by aspiration cultures of the bone or by bone biopsy cultures. Radiology stud-

*Dr. Smith is Director, Department of Medicine, Saint Michael's Medical Center, Newark. Correspondence may be addressed to Dr. Smith, Saint Michael's Medical Center, 268 Martin Luther King, Jr. Blvd., Newark, NJ 07102.

ies and bone and gallium scans were used to support the diagnosis. A clinical cure was defined as resolution of local and systemic symptoms of the patients and a bacteriologic cure was defined as a sterile culture. The patients with osteomyelitis who had no further drainage and had radiologic changes such as resolving osteomyelitis were evaluated as a clinical improvement. Those patients who had complete resolution of their osteomyelitis were evaluated as clinical cure.

Pneumonia was diagnosed by a positive culture, positive gram stains of the sputum, and radiographic evidence of a pulmonary infiltrate. Cure of pneumonia was established when sputum cultures were negative and the infiltrate in the chest x-ray had resolved.

Skin and soft tissue infection was based on a positive culture and the clinical involvement of the skin and soft tissue. The skin and soft tissue infections were defined as cured when the tissues healed to their normal visual and tonic configuration.

A diagnosis of pyelonephritis was made by fever, costovertebral angle tenderness, and positive culture. A cure was defined as a sterile culture at five to nine days post-therapy, and when clinical symptoms had abated.

In the cases of meningitis, typhoid fever, and gangrene, the appropriate sites were cultured (cerebrospinal fluid, blood, or urine) and a diagnosis was based on proper isolation of the infecting organism. These miscellaneous entities were defined as cured when appropriate cultures were sterile. In our patient with meningitis, a cell count with differential glucose and protein was done on the cerebrospinal fluid. This was repeated for a total of four times throughout the patient's two-month course.

All of the patients in this study were monitored for toxicity of ceftriaxone; complete blood counts, including differential counts and platelet counts, were done on each patient. Other laboratory tests included BUN, creatinine, SGOT, SGPT, alkaline phosphatase, bilirubin, and urine analysis (biochemical and microscopic). This was repeated every four days while the patient was on ceftriaxone or where clinically indicated. The patients were followed daily by a member of our attending infectious diseases staff.

RESULTS

In the 20 patients who were treated for osteomyelitis with ceftriaxone, 16 patients had a bacteriologic cure of their disease. Three patients had resistant organisms but did show clinical improvement after being treated with ceftriaxone. Patient 12, having sensitive organisms to ceftriaxone, did not respond clinically to the medication. The patient was treated with vancomycin and rifampin and responded clinically and a cure was obtained. There were 9 chronic cases and 7 acute cases that were cured, and several of these patients had numerous bacterial isolates. The organisms isolated in the 17 sensitive cases included 11 isolates of *Staphylococcus aureus*, 4 isolates of *S. epidermidis*, 4 isolates of *Escherichia coli*, 2 isolates of *Proteus mirabilis*, 2 isolates of *Acinetobacter anitratus*, 2 isolates of *Enterobacter cloacae*, and 1 isolate of *Salmonella enteritidis* and *Pseudomonas aeruginosa*. *Bacteroides ovatus* was resistant to ceftriaxone and clindamycin in patient 11. However, it was sensitive to the tetracyclines. The 3 patients whom resistant organisms were found had the following bacterial isolates; 2 isolates of *S. epidermidis*; isolate each of enterococci and *E. cloacae*. Patient had a hip prosthesis in place which may have tributed to failure of ceftriaxone. In our series, 2 p tients required surgical intervention because abscess cavities within the bone. One of these patier (11) later was found to have Ehlers-Danlos disea This may have attributed to her poor wound healir

Eleven of our patients were treated as outpatier after initial hospitalization and evaluation. All exce 1 could tolerate the intramuscular injections as outp tients and that patient was readmitted for intraveno therapy. Ceftriaxone was well tolerated by our patien only 1 patient had a transient rise of liver tra aminases. In our 9 chronic cases and 7 acute cas that were cured, improvement was noted radiologica The chronic cases either had resolving osteomyeli or resolution of osteomyelitis on x-ray and bone a gallium scans. All of our 7 acute cases had compl resolution of osteomyelitis on x-ray and bone galli scans. The dosing interval in our osteomyelitis ca was 12 to 24 hours and total dosages ranged from to 84 gm over a time interval of 15 to 44 days. Th chronic osteomyelitis patients need long-term eva ation to see if there was a clinical and bacteriolo cure under the period of observation.

Our skin and soft tissue infections included fo cases of cellulitis; pathogens isolated includ *Staphylococcus aureus* (three), group a be hemolytic strep (one), and group b strep (one). Th patients responded well to therapy with complete re lution of their lesions. Other sites of infection includ facial abscess, postoperative thoracotomy wound inf tion, and ulcer of the right leg. Patient 25, with fac abscess, had recurrent abscess since childhood a recurrence could not be prevented. The patient h extensive immunologic and bacteriologic studies. Jo syndrome was a consideration, but the evaluation w negative for any disease entity. *S. epidermidis* w isolated from the facial abscess. *S. aureus* a enterococci were isolated from the postoperat wound infection and *S. aureus* was isolated from t leg ulcer. All of these patients responded to thera with complete resolution of their infections.

We had four cases of pneumonia and our isola included *Streptococcus pneumoniae* (two), group beta-hemolytic streptococci (two), and group b b hemolytic streptococci (one). All responded to thera and had complete resolution of chest x-ray findir within five to six days and sterile sputum or sputum.

All patients with pyelonephritis had *Escherichia c* (four) and *Proteus mirabilis* (one). All patients sponded with clearing of urine of bacteria and re lution of costovertebral angle tenderness and feve

Miscellaneous infections treated with ceftriaxone cluded: meningitis, typhoid fever, and gangrene of t right great toe. Ceftriaxone was used to tr *Enterobacter cloacae* meningitis. The patient suffe severe trauma in an automobile accident and had fr tured vertebrae with leaking cerebrospinal fluid. had prior treatment with ampicillin and gentamicin another hospital. The levels of gentamicin were the

TABLE

Site of Clinical Infection, Bacteriology, Response, and Duration of Therapy in 38 Patients Who Received Ceftriaxone for 5 or More Days

Site of Infection	Bacteria Isolated	Response Clinically	Days of Therapy
Osteomyelitis	*Staphylococcus aureus*	Cure	42
Osteomyelitis	*Escherichia coli*	Cure	21
Osteomyelitis	Enterococci, *Enterobacter cloacae*	Failure	6
Osteomyelitis	*Salmonella enteritidis*	Cure	34
Osteomyelitis	*S. aureus*	Cure	46
Osteomyelitis	*S. epidermidis*	Cure	42
Osteomyelitis	*S. aureus*	Cure	40
Osteomyelitis	*S. aureus*	Cure	42
Osteomyelitis	*S. epidermidis*	Improved clinically but bacteriologic failure	42
Osteomyelitis	*Acinetobacter anitratus, E. cloacae, E. coli, S. aureus*	Cure	42
Osteomyelitis	*E. cloacae, S. aureus, E. coli, Bacteroides ovatus*	Cure	42
Osteomyelitis	*S. aureus, S. epidermidis*	Clinical failure	15
Osteomyelitis	*S. epidermidis*	Failure	42
Osteomyelitis	*P. mirabilis, S. epidermidis*	Cure	15
Osteomyelitis	*Acinetobacter anitratus*	Cure	41
Osteomyelitis	*P. mirabilis*	Cure	43
Osteomyelitis	*S. aureus*	Cure	42
Osteomyelitis	*S. aureus*	Cure	42
Osteomyelitis	*S. aureus*	Cure	42
Osteomyelitis	*Pseudomonas aeruginosa, E. coli*	Cure	35
Cellulitis	*S. aureus*	Cure	10½
Cellulitis	*S. aureus*	Cure	7
Cellulitis	*S. aureus*	Cure	8
Cellulitis	*S. aureus*, Group a *Streptococcus*	Cure	17½
Facial abscess	*S. epidermidis*	Clinical improvement	11
Wound infection	*S. aureus*, Enterococci	Cure	21
Leg ulcer	*S. aureus*	Cure	8
Pneumonia	*H. influenza*	Cure	6
Pneumonia	*Streptococcus pneumoniae*	Cure	5
Pneumonia	Group a beta streptococci	Cure	8
Pneumonia	*Streptococcus pneumoniae*	Cure	6
Pyelonephritis	*E. coli*	Cure	6
Pyelonephritis	*E. coli, P. mirabilis*	Cure	11
Meningitis	*E. cloacae*	Cure	27
Typhoid Fever	*Salmonella typhi*	Cure	11
Gangrene great toe	*Serratia marcescens*	Cure	14

peutic at peak and trough and the maximum dose of ampicillin was given (12 gm), but the *E. cloacae* was not eradicated from the cerebrospinal fluid. In our hospital, the *E. cloacae* (MIC 2.0 mg/ml) was resistant to ampicillin but sensitive to gentamicin. The patient was treated with gentamicin 60 mg intravenously every Q8H for 34 days and intrathecal gentamicin 7 mg three times daily for 9 days concurrently with ceftriaxone (2 g intravenously Q8H). After 6 days of combined drug therapy repeat cultures from the cerebrospinal fluid were sterile. The patient went on to have an uneventful recovery.

Our one case of typhoid fever responded well to ceftriaxone. *Salmonella typhi* was isolated from three blood cultures but was not isolated from the stool. Repeat blood cultures, done five days after treatment with ceftriaxone were sterile. The patient was treated with intramuscular/intravenous ceftriaxone for seven days and for four days as an outpatient. The patient then was followed up by her local medical doctor; at the end of six months she has had no further relapse of her disease.

The patient with gangrene of the right great toe had *Serratia marcescens* and *Escherichia coli* isolated from the wound. Treatment with ceftriaxone resulted in sterile cultures but eventually the toe was amputated. The patient recovered.

In our study, ceftriaxone has been found to be highly active against gram-positive and gram-negative organisms. Ceftriaxone also inhibited members of the enterobacteriacae at lower concentrations than older cephalosporins and its activity against *Escherichia coli* and *Klebsiella pneumoniae* was similar to that of cefotaxime and moxalactam.[5] The long elimination half-life of ceftriaxone of approximately 8.2 hours should make this drug very useful for the treatment of outpatients, especially those with osteomyelitis.[4] The advantage of using ceftriaxone in the treatment of osteomyelitis is that its prolonged serum half-life allowed us to treat 11 of our 20 patients as outpatients, with a once-a-day treatment regimen. All outpatients tolerated the intramuscular injections except 1 patient who was readmitted for intravenous treatment. In the 3 patients with osteomyelitis who failed clinically, 1 of these patients had a hip prosthesis in place; 2 had *Staphylococcus epidermidis* and 1 of these patients had enterococci and *Enterobacter cloacae*. Ceftriaxone, like other new B-lactam antibiotics, has reduc activity against staphylococci species compared to t first and second generation cephalosporins such cephalothin and cefamandole.[6, 7] However, t achievable serum concentrations of ceftriaxone far ceed the MIC for most staphylococcal specie Cephalosporins in general are not very effecti against the enterococci.[8] Only 1 patient had a tran ent increase in SGOT and SGPT which resolved. It a will be beneficial in those patients with serio bacterial infections who can be treated on an outp tient basis/osteomyelitis and typhoid fever. This ficacy along with favorable pharmacokinetics sho that ceftriaxone should be useful in the treatment serious bacterial infections. If this drug is priced pr erly, it could revolutionalize the method of treati osteomyelitis, soft tissue infections, pneumonias, a conceivably even meningitis as an outpatie procedure. This is a major factor in hospital cost co tainment today as hospital stay was reduced by percent in major illnesses.

REFERENCES

1. Patel IH, Weinfeld RE, Konikoff J, Parsonnet M: Pharm cokinetics and tolerance of ceftriaxone in humans af single-dose intramuscular administration in water and li caine diluents. *Antimicrob Agents Chemother* 21:402-4 1982.
2. Epstein J, Hasselquist S, Simon G: Efficacy of ceftr xone in serious bacterial infections. *Antimicrob Age Chemother* 21:402-406, 1982.
3. Johnson RC, Bey RE, Wolgamot SJ: Comparison of t activities of ceftriaxone and penicillin G against experim tally induced syphilis in rabbits. 1982. *Antimicrob Age Chemother* 21:984-988, 1982.
4. Beskid G, Cleeland W, Deloreno A, Trown PW: In v activity of ceftriaxone (Ro 13-9904) a broad spectrum se synthetic cephalosporin. *Antimicrob Agents Chemot* 20:159-167, 1981.
5. Neu H, Merpol N, Kwung F: Antibacterial activity of triaxone (Ro 13-9904) a B-lactamase stable cephalospo *Antimicrob Agents Chemother* 19:44-423, 1981.
6. Eickhoff TC, Ehret J: Comparative in vitro studies of 13-9904 a new cephalosporin derivative. *Antimicrob Age Chemother* 18:240-242, 1981.
7. Angehrn P, Probst P, Reiner R, Then R: Ro 13-990 long-acting broad spectrum cephalosporin: In vitro and vivo studies. *Antimicrob Agents Chemother* 18:913-9 1980.
8. Thompson RL, Wright AJ: Cephalosporin antibiot *Mayo Clinic Proc* 58(2): 79-87, 1980.



The Easy Alternative...

Lease the car of your choice from us. You choose the model, color and options ... we do the rest! Our leasing program can be custom-tailored to include insurance, if you desire. We feature personalized service and the extra attention to detail you're looking for.

Call us today at (201) 257-2300 or (212) 964-0037 to lease YOUR car ... the convenient, easy way.

RUTGERS LEASING inc.

6 Connerty Court • East Brunswick, NJ 08816

Doctors: Write your own prescription to cure insurance pains . . .

℞ Prescription

lame MSNJ Member

MSNJ Group
Blue Cross/Blue Shield Major Medical and Dental Insurance

that provides:

- **Flexible plans**
- **Comprehensive benefits**
- **Low, competitive rates**
- **Centralized Administration**

Designed and Administered by
DONALD F. SMITH & ASSOCIATES

℞ Prescription

Name _____

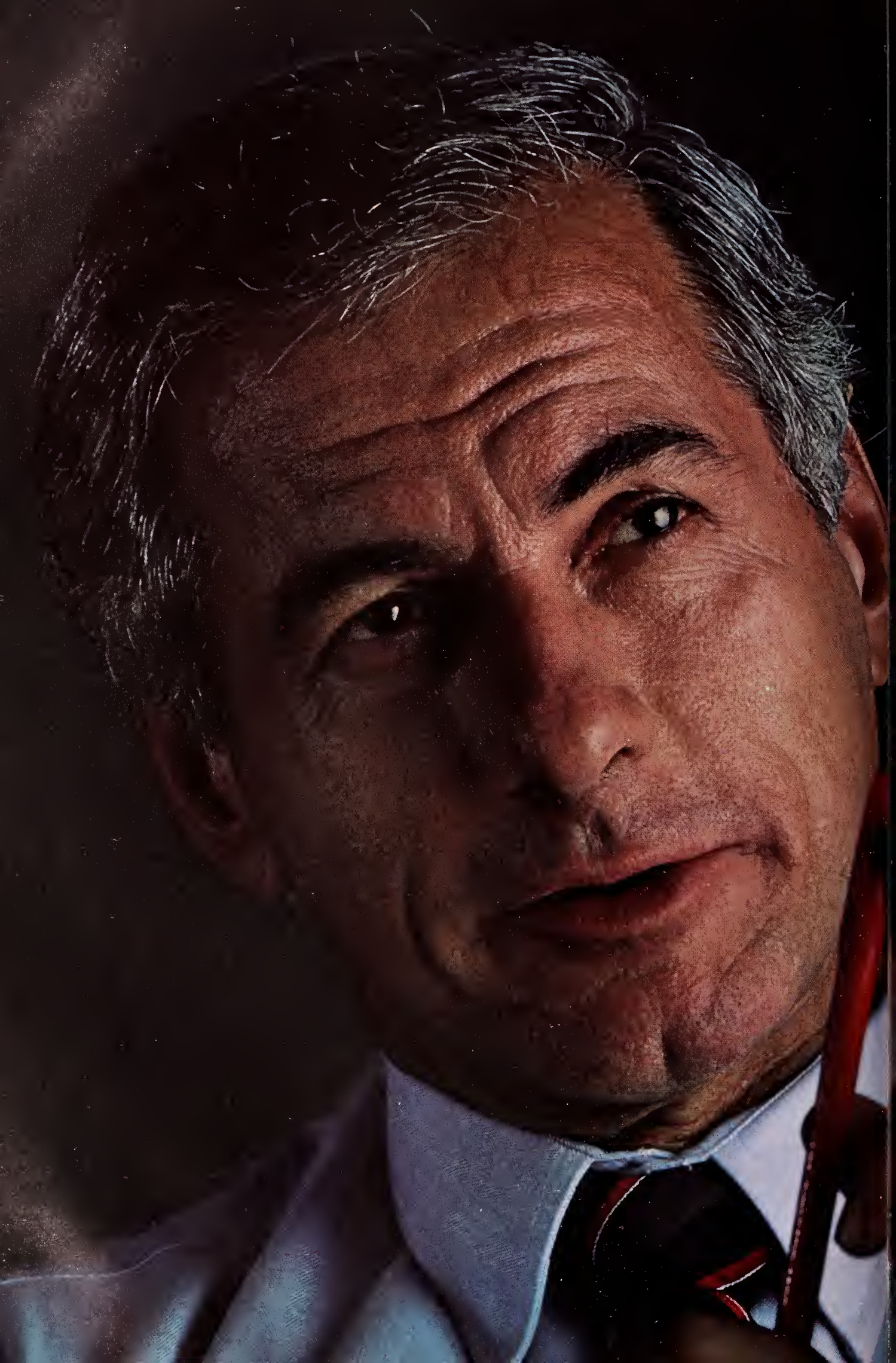
Address _____

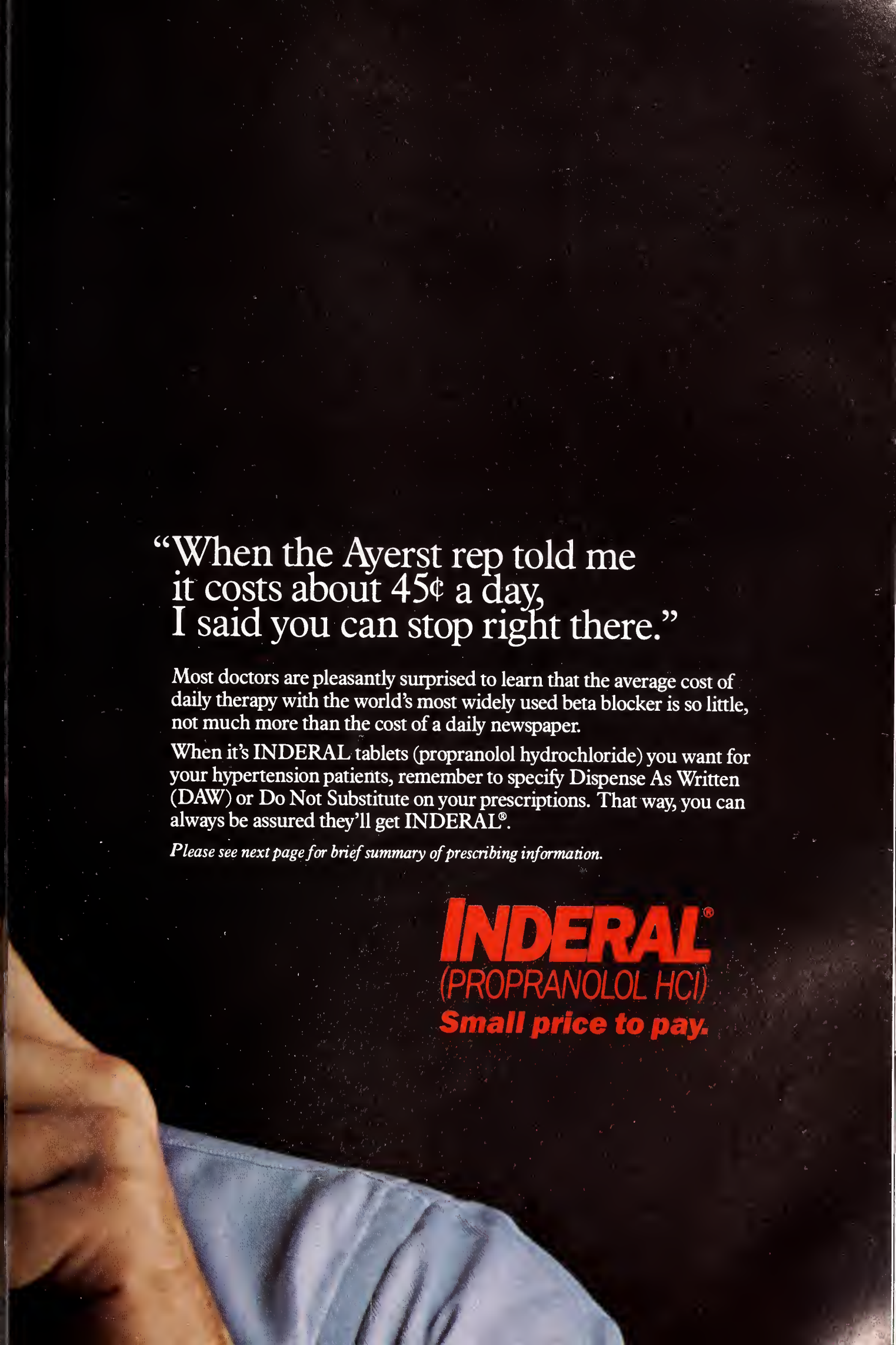
Phone _____

Please send more information on the MSNJ

- ☐ Blue Cross/Blue Shield Program
- ☐ Major Medical Program
- ☐ Group Dental Program

Return to:
Donald F. Smith & Associates
One Airport Place, Route 206 North
P.O. Box 2197,
Princeton, New Jersey 08540
(609) 924-8700, (201) 622-6046

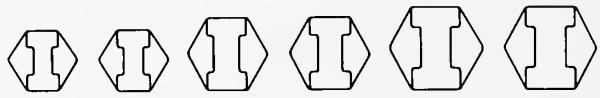



"When the Ayerst rep told me it costs about 45¢ a day, I said you can stop right there."
Most doctors are pleasantly surprised to learn that the average cost of daily therapy with the world's most widely used beta blocker is so little, not much more than the cost of a daily newspaper.
When it's INDERAL tablets (propranolol hydrochloride) you want for your hypertension patients, remember to specify Dispense As Written (DAW) or Do Not Substitute on your prescriptions. That way, you can always be assured they'll get INDERAL®.
Please see next page for brief summary of prescribing information.
INDERAL®
(PROPRANOLOL HCl)
Small price to pay.

"When the Ayerst rep told me it costs about 45¢ a day, I said you can stop right there."

INDERAL® TABLETS

(PROPRANOLOL HCl)



10 mg 20 mg 40 mg 60 mg 80 mg 90 mg*

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

INDERAL® (propranolol hydrochloride) Tablets

CLINICAL PHARMACOLOGY

The Beta-Blocker Heart Attack Trial (BHAT) was a National Heart, Lung and Blood Institute-sponsored multicenter, randomized, double-blind placebo-controlled trial conducted in 31 U.S. centers (plus one in Canada) in 3,837 persons without history of severe congestive heart failure or presence of recent heart failure, certain conduction defects; angina since infarction, who had survived the acute phase of myocardial infarction. Propranolol was administered at either 60 or 80 mg t.i.d. based on blood levels achieved during an initial trial of 40 mg t.i.d. Therapy with INDERAL, begun 5-21 days following infarction, was shown to reduce overall mortality up to 39 months, the longest period of follow-up. This was primarily attributable to a reduction in cardiovascular mortality. The protective effect of INDERAL was consistent regardless of age, sex or site of infarction. Compared to placebo, total mortality was reduced 39% at 12 months and 26% over an average follow-up period of 25 months. The Norwegian Multicenter Trial in which propranolol was administered at 40 mg q.i.d. gave overall results which support the findings in the BHAT.

Although the clinical trials used either t.i.d. or q.i.d. dosing, clinical, pharmacologic and pharmacokinetic data provide a reasonable basis for concluding that b.i.d. dosing with propranolol should be adequate in the treatment of post-infarction patients.

CLINICAL: In the BHAT, patients on INDERAL were prescribed either 180 mg/day (82% of patients) or 240 mg/day (18% of patients). Patients were instructed to take the medication 3 times a day at mealtimes. This dosing schedule would result in an overnight dosing interval of 12 to 14 hours which is similar to the dosing interval for a b.i.d. regimen. In addition, blood samples were drawn at various times and analyzed for propranolol. When the patients were grouped into tertiles based on the blood levels observed and the mortality in the upper and lower tertiles were compared, there was no evidence that blood levels affected mortality.

PHARMACOLOGIC: Studies in normal volunteers have shown that a 90 mg b.i.d. regimen maintains beta blockade at, or above, the minimum for 60 mg t.i.d. dosing for 24 hours even though differences occurred at two time intervals. At 10-12 hours after the first dose of the day, t.i.d. dosing gave more beta blockade than b.i.d. dosing; at 20-24 hours the trend of the relationship was reversed. These relationships were similar in direction to those observed for plasma propranolol levels (see Pharmacokinetic).

PHARMACOKINETIC: A bioavailability study in normal volunteers showed that the blood levels produced by 180 mg/day given b.i.d. are below those provided by the same daily dosage given t.i.d. at 10-12 hours after the first dose of the day but above those of a t.i.d. regimen at 20-24 hours. However, the blood levels produced by b.i.d. dosing were always equivalent to or above the minimum for t.i.d. dosing throughout the 24 hours. In addition, the mean AUC on the fourth day for the b.i.d. regimen was about 17% greater than for the t.i.d. regimen (1,194 *vs.* 1,024 ng/ml• hr).

CONTRAINDICATIONS

INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS

CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS.

INDERAL (propranolol hydrochloride) should be administered with caution since it m bronchodilation produced by endogenous and exogenous catecholamine stimulatio receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking the prior to major surgery is controversial. It should be noted, however, that the impaired the heart to respond to reflex adrenergic stimuli may augment the risks of general an and surgical procedures.

INDERAL, like other beta blockers, is a competitive inhibitor of beta-receptor agon its effects can be reversed by administration of such agents, e.g., dobutamine or iso terenol. However, such patients may be subject to protracted severe hypotension. Di starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the ap ance of certain premonitory signs and symptoms (pulse rate and pressure changes) hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism fore, abrupt withdrawal of propranolol may be followed by an exacerbation of sympto hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid functio

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have reported in which, after propranolol, the tachycardia was replaced by a severe brad requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS

General: Propranolol should be used with caution in patients with impaired hepatic o function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patie should be told that INDERAL may interfere with the glaucoma screening test. Withdr lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart d elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such a pine should be closely observed if INDERAL is administered. The added catecholam blocking action may produce an excessive reduction of resting sympathetic nervous which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or static hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animal been conducted to evaluate toxic effects and carcinogenic potential. In 18-month stu both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence o cant drug-induced toxicity. There were no drug-related tumorigenic effects at any of age levels. Reproductive studies in animals did not show any impairment of fertility t attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic studies at doses about 10 times greater than the maximum recommended human do

There are no adequate and well-controlled studies in pregnant women. INDERAL be used during pregnancy only if the potential benefit justifies the potential risk to the

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercise INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Most adverse effects have been mild and transient and have rarely required the with therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block, sion; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by ins lassitude, weakness, fatigue; reversible mental depression progressing to catatonia disturbances; hallucinations; an acute reversible syndrome characterized by disorie for time and place, short-term memory loss, emotional lability, slightly clouded senso and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diar constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined wit and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has be reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male im tence, and Peyronie's disease have been reported rarely. Oculomucocutaneous rea involving the skin, serous membranes and conjunctivae reported for a beta blocker lol) have not been associated with propranolol.

*The appearance of INDERAL tablets is a registered trademark of Ayerst Laborato

9371/1

Ayerst® AYERST LABORATORIES
New York, N.Y. 10017

Aortic and Mitral Valve Replacement: Part 1*

Philip J. Olivieri, M.D., and John B. Kostis, M.D., New Brunswick**

The development of valvular protheses and reconstructive procedures has revolutionized the management of valvular heart disease. Part 1 will discuss the clinical presentation and natural history of aortic stenosis, mitral stenosis, aortic regurgitation, and mitral regurgitation without surgery.

It has been nearly a quarter of a century since the first aortic and mitral prostheses were inerted by Harken, Starr, and Edwards.[1,2] Since then, alve replacement has revolutionized the management f valvular heart disease. The clinical course of the reprosthetic era, often characterized by a latent eriod of variable duration followed by inexorable derioration and death, has been modified so that a eturn to normal or near-normal cardiac function is ossible.

As Kirklin and Pacifico have stated, "The value to the atient of valve repair or replacement is determined by ne resulting improvement in the length and quality f life over that imposed by the natural history of the isease."[3] Accurate knowledge of the natural history of ne valvular lesions is thus of great importance.

This article reviews the natural history of aortic and itral stenosis and regurgitation, the results of surery, and the crucial issue of timing of surgical interention. Finally, special considerations including repair of native valves and replacement of prosthetic alves will be discussed.

ORTIC STENOSIS

Aortic stenosis is characterized by a reduction in the ormal (2 to 4 cm^2) valve area and a systolic pressure radient between the left ventricle and the aorta at the alvular level. It usually develops across nonobstructed bicuspid valves damaged by turbulent flow with secondary calcification.[7] Anatomically normal valves also can calcify ("wear and tear" stenosis in the elderly). Congenital unicuspid, bicuspid, or tricuspid stenosis is seen and rheumatic stenoses occur. Regardless of the etiology, aortic stenosis is a self-perpetuating process whose rate of progression is not predictable.

Bogart et al. studied 11 adult patients (mean age 48 years) with two cardiac catheterizations (mean interval 59 months); they had not had aortic valve surgery.[8] They found progression in 10 patients with a decrease of mean valve area from 1.2 ± 0.2 cm^2 to 0.7 ± 0.1 cm^2; and an increase in mean left ventricular-aortic gradient from 31 ± 4 mm/Hg to 75 ± 13 mm/Hg. The shortest time interval was from 27 to 29 months. Cheitlin et al. performed 31 sets of catheterizations (62 catheterizations in total) on 29 unoperated adults with aortic stenosis (mean interval, 43.5 months.)[9] They found an increase in the peak systolic gradient across the aortic valve of at least 50 percent in 16 of the 31 studies. In the progressive group, the average rate of increase was 1.3 mm/Hg/month with a maximum rate of 3.8 mm/Hg/month observed. Although a long latent period typifies aortic stenosis, it is clear that the pro-

*Part 2 will appear in the next issue of *The Journal*, MSNJ.

**From the Division of Cardiovascular Diseases, UMDNJ-Rutgers Medical School. Correspondence may be addressed to Dr. Kostis, UMDNJ-Rutgers Medical School, CN 19, New Brunswick, NJ 08903.

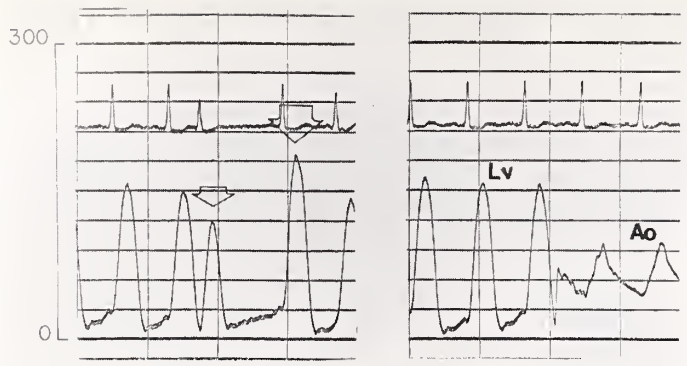


Figure 1—Aortic stenosis. Left panel: Postextrasystolic potentiation. Note the increased systolic pressure in the postextrasystolic beat (large arrow). Right panel: Transvalvular gradient on left ventricular (LV) to aortic (Ao) pullback.

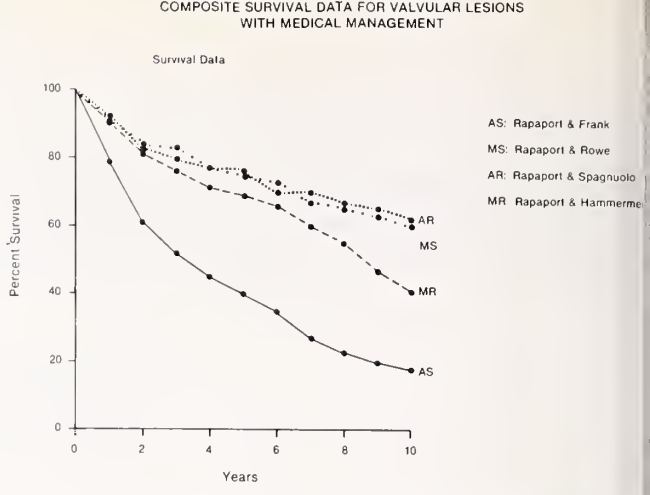


Figure 2—Composite survival data for valvular lesions v medical management.

gression of this lesion can be quite rapid. The conditions predisposing toward rapid progression remain largely unknown. Wagner and Selzer recently reviewed 50 adult patients (mean age 54 ± 4 years) with aortic stenosis (peak left ventricular-aortic gradient 38 ± 27 mm/Hg; valve area 1.3 ± 0.7 cm^2.)[10] There were 7 patients with congenital and 22 patients with rheumatic lesions. An older group of patients (mean age 62 versus 51 ± 9 years) had degenerative-calcific aortic stenosis. A second cardiac catheterization 3.5 ± 3 years later revealed a gradient of 57 ± 30 mm/Hg and a valve area of 0.8 ± 0.4 cm^2 for all patients. The group divided into 21 rapid progressors (0.3 ± 0.21 cm^2/year) and 29 slow progressors (0.02 ± 0.08 cm^2/year). Seventy-six percent of the rapid progressors had degenerative-calcific aortic stenosis as opposed to only 21 percent of the slow progressors.

Adults, unlike children, rarely are asymptomatic when significant aortic stenosis is present. The presence of symptoms in medically managed aortic stenosis suggests an ominous prognosis: angina, syncope, and congestive heart failure portend death on the average of five, three, and two years, respectively.[11] In addition, even asymptomatic patients remain at increased risk for sudden death. The physical findings include a narrow pulse pressure, delayed carotid upstroke and peripheral pulses, sustained left ventricular heave, S4 gallop, and a harsh aortic systolic ejection murmur radiating to the carotid arteries. These findings together with noninvasive data select patients for invasive study. The noninvasive data include valve calcification on chest x-ray or fluoroscopy, left ventricular hypertrophy with strain pattern on electrocardiogram, and increased left ventricular posterior wall or septal thickness, or nonvisualized aortic leaflets on echocardiogram. Cardiac catheterization, with the demonstration of a left ventricular-aortic gradient greater than 50 mm/Hg (Figure 1) or a calculated valve area less than 0.4 cm^2/m^2 body surface area, is diagnostic of hemodynamically important aortic stenosis. The aortic valve area should be determined when possible (i.e. in the absence of concomitant aortic regurgitation) since patients with critical stenosis may have small left ventricular-aortic gradients due to a decrease in cardiac output.

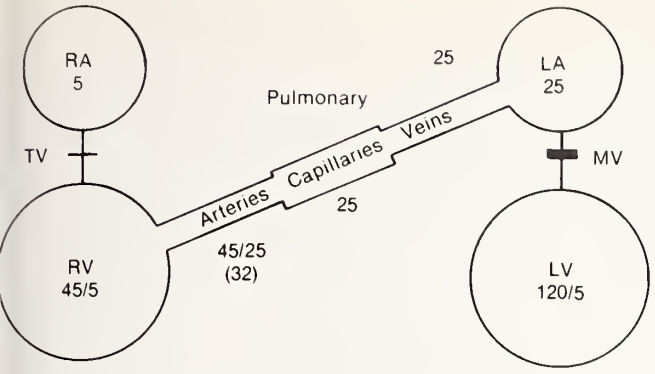
The poor prognosis of aortic stenosis with medical management has been documented in several studies (Table). These studies should be compared with caution: statistical methods differ and current medi practices obviously are not reflected in the early ports. Nevertheless, the data of Bergeron et al., Wo Takeda et al., and Rotman et al. reflect a wide ra of clinical experience.[12-15] Combined data from t studies of Frank et al. and Rapaport are shown Figure 2.[16,7] The five-year and ten-year survivals in t pooled group are 40 percent and 18 percent, respecti ly. More recently, Schwarz et al. found a 21 percent year survival among 19 adults with severe ao stenosis (left ventricular-aortic gradient 89.6 ± 1 mm/Hg) who refused surgery.[17] This dismal outco contrasted sharply with the results of surgical m agement.

MITRAL STENOSIS

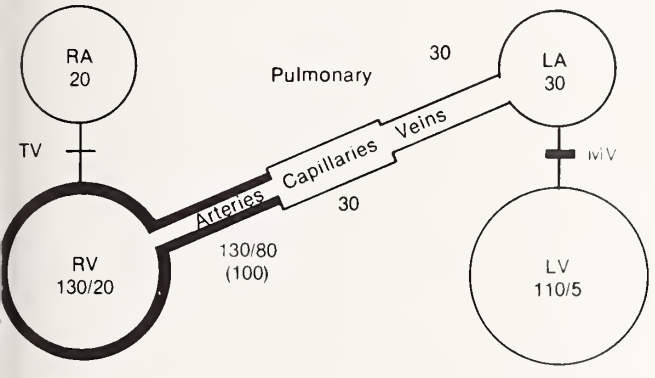
Mitral stenosis is characterized by a reduction in t normal (3 to 4 cm^2) valve area and a diastolic press gradient between the left atrium and the left ventri at the valvular level. It does not cause pressure or v ume overload of the left ventricle. The etiology of mit stenosis almost exclusively is rheumatic. Oth etiologies, including congenital mitral stenosis, rare. However, the lesion probably is perpetuated b nonspecific process akin to that for aortic steno rather than a continuing rheumatic valvulitis.[18]

The natural history of mitral stenosis depends up the interplay of two obstructions to blood flow: a "p mary" obstruction at the mitral valve and a "secon ary" one at the pulmonary arterioles (Figure 3). In t average patient, the lesion is hemodynamically significant during the first 10 years after the init rheumatic insult when the valve area is above 2.5 c Dyspnea develops on exertion after 20 years when t valve area drops below 2.5 cm^2 and appears at r when the area drops below 1.5 cm^2. Pulmonary hyp tension occurs when the valve area is reduced bel 1.0 cm^2. Unlike aortic stenosis, where symptoms her a short, severe course until death, mitral stenosis a gradually progressive symptomatic lesion.[19] Int current complications such as infective endocardi atrial fibrillation, or peripheral embolization serve alter the basic course.

The physical findings of mitral stenosis are a lo S1 (increased M1), opening snap (S2-OS interval l than 0.08 seconds with significant lesions), a apical diastolic rumble. Left atrial enlargement can



A. Mitral stenosis without pulmonary vascular disease



B. Mitral stenosis with pulmonary vascular disease: "secondary stenosis"

gure 3—Obstructions to blood flow in mitral stenosis. Nor-al values: Right atrium 5, right ventricle 20/5, pulmonary tery 20/8 (mean 12), pulmonary capillary and vein 6, left rium 6, left ventricle 120/6 mm/Hg.

en on the chest x-ray and left atrial abnormality is esent on the electrocardiogram. Echocardiographic idings essentially are diagnostic: thickened, ab-rmally moving mitral leaflets on M-mode (Figure 4) directly visualized small orifice on short-axis view, o-dimensional mode. Cardiac catheterization still is quired to measure the transvalvular gradient (Figure and to calculate the valve area (in the absence of ncomitant mitral regurgitation), to measure the lmonary vascular resistance, and to determine the esence of concurrent valvular or coronary artery ions.

Survival data in mitral stenosis are presented in the ble. Data reflect not only the level of available medi-l therapy but also the stage at which the patients itially are assessed. Rowe et al. reported 61 percent -year survival among 250 medically treated pa-nts.[20] One-half were asymptomatic when the initial agnosis was made and one-third were below the age 20 years. A 115-patient subgroup of the 250 patients aracterized by older age and more advanced disease s followed for 20 years: 45 percent survived for 11 ars, 30 percent for 15 years, and 21 percent for 20 ars. Forty-three percent of the subgroup with milder sease (Rowe's class 1) had 40 percent 20-year rvival, whereas 57 percent with greater dysfunction owe's classes 2 and 3) had only 8 percent 20-year rvival. These data are consistent with studies by esen, Roy and Gopinath, and Munoz et al.[21-23]

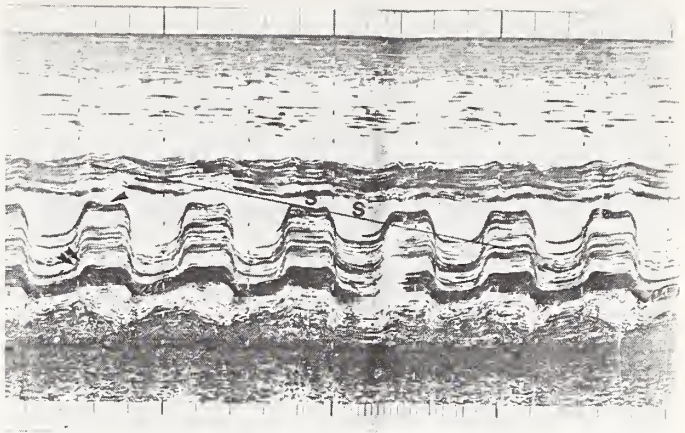


Figure 4—Mitral stenosis. This M-mode echocardiogram demonstrates the classic appearance of mitral stenosis. The mitral leaflets are thickened and there is anterior diastolic movement of the posterior leaflet (double arrow). The E-to-F slope of the anterior leaflet (single arrow) is reduced greatly.

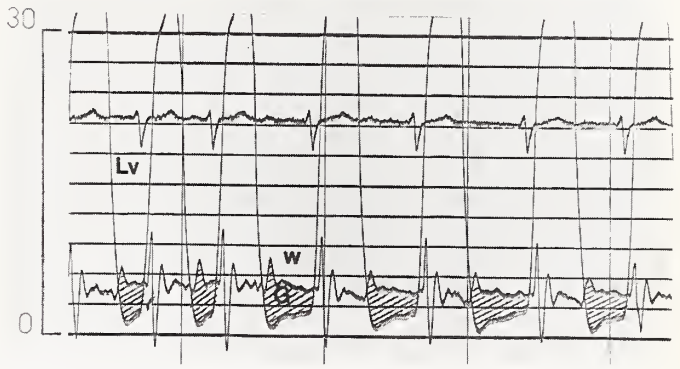


Figure 5—Mitral stenosis. Transvalvular pressure gradient obtained by simultaneous recording from catheters in the left ventricle (LV) and the pulmonary capillary wedge (W). The variable left ventricular filling in atrial fibrillation accounts for the beat-to-beat changes.

Rapaport reported 80 percent 5-year and 60 percent 10-year survivals in an unselected group of 133 patients[7]. Pooled data from the studies of Rowe et al. and Rapaport are shown in Figure 2. The 5-year and 10-year survivals are 75 percent and 60 percent, respectively.

AORTIC REGURGITATION

Aortic regurgitation is present when the left ventricle receives backward flow from the aorta during diastole. Rotman et al. reported 59 patients whose lesions represented diverse etiologies.[15] They included rheumatic (39 percent), unknown (25 percent), subacute bacterial endocarditis (10 percent), Marfan's syndrome or cystic medial necrosis (8 percent), combined rheumatic/endocarditis (7 percent), luetic (7 percent), ruptured valve (2 percent), and dissecting aneurysm (2 percent). Asymptomatic periods measured in decades were frequent with rheumatic, connective tissue, or luetic lesions.

The most common presentation of aortic regurgitation is congestive heart failure. Angina occurs in one-third of patients but the typical chronic chest pain most likely is thoracic wall pain from the hyperdynamic precordium.[24] Syncope and sudden death are rare. Physical findings include a hyperdynamic precordium with an inferolaterally displaced point of maximum impulse. The S2 is diminished (decreased A2) and there is an aortic decrescendo diastolic

TABLE

Natural History of Valvular Lesions

	Aortic Stenosis		Mitral Stenosis
Bergeron et al. 1954[12]	Retrospective, autopsy series of 100 symptomatic patients: 50 percent survival 2 years after onset of angina, syncope, atrial fibrillation, or failure. Less than 25 percent 5-year survival.	Rowe et al. 1960[20]	Series of 250 patients (one-hal asymptomatic, one-third les than 20 years old) with 61 per cent overall 10-year survival: 8 percent class 1, 42 percent clas 2, 15 percent class 3 (Rowe' classes). An older 115-patien subgroup had an overall 21 per cent 20-year survival: 40 percen class 1, 8 percent classes 2 an 3.
Wood 1958[13]	Series of 64 symptomatic patients with clinically severe stenosis (48 pure stenosis, 16 stenosis/regurgitation). One-half lost to followup 1 to 7 years observation. Fifty-six percent of the remaining 32 patients died.	Olesen 1962[21]	Series of 271 symptomatic pa tients (average age 41.5 year old) first seen 1933-1949 wit overall 34 percent 10-yea survival; NYHA class III (B,C): 6 percent 5-year, 30 percent 1C year survival; NYHA class IV (D 15 percent 5-year, 0 percent 1C year survival.
Takeda et al.[14]	Series of 60 patients with isolated stenosis. Eighty-two percent dead after 4 to 15 years. Average age at death was 62.5 years.	Roy and Gopinath 1968[22]	Series of 100 patients with mil (80 percent 8-year survival) c severe (47 percent 8-yea survival) stenosis.
Rotman et al. 1971[15]	Surgical series with 25 medically treated patients (10 operative candidates, 15 nonoperative candidates). Fifty percent (5/10) 6.1-year survival versus 79 percent 4.5-year survival.	Rapaport 1975[7]	Series of 133 unselected patient with survivals of 80 percent at years and 60 percent at 10 year
Frank et al. 1973[16]	Series of 15 patients with stenosis. Survivals of 48 percent at 5 years and 20 percent at 10 years.	Munoz et al. 1975[22]	Surgical series with 58 sympt matic patients (NYHA classes III, IV) treated medically. Fort five percent 5-year survival.
Rapaport 1975[7]	Series of 42 unselected patients with survivals of 38 percent at 5 years and 20 percent at 10 years.		
Schwarz et al. 1982[17]	Surgical series with 19 medically treated patients. Twenty-one percent 3-year survival.		

(continue

murmur. Clues to chronic, hemodynamically significant aortic regurgitation include a widened pulse pressure (greater than 60 mm/Hg) and concomitant peripheral signs (de Musset's sign: head bobbing; and Quincke's sign: subungual capillary pulsations), diastolic pressure less than 70 mm/Hg (Traube's sign: femoral "pistol shots"), and reversed peripheral diastolic blood flow (Duroziez's sign: femoral systolic/diastolic bruits with proximal/distal compression). The pulse pressure:systolic pressure ratio is greater than 50 percent. The chest x-ray shows left ventricular enlargement and the electrocardiogram reveals systolic or diastolic overload left ventricular hypertrophy (producing tall and upright T waves in the precordial leads instead of the typical "strain" pattern in V_{5-6} with systolic overload). The echocardiogram may demonstrate left ventricular enlargement and hyperdynamic function (Figure 6). Spagnuolo et al. identified a triad of left ventricular enlargment, electrocardiographic abnormalities (high voltage, ST-segment depression, and T-wave inversion), and abnormal blood pressure (systolic pressure greater than 140 mm/Hg, diastolic pressure less than 40 mm/Hg, or both) in 31 patients with rheumatic aortic regu i- tation.[25] Thirty-three percent of the group either d or had congestive heart failure or angina within e year, 48 percent within two years, 65 percent w h three years, and 87 percent within six years of acqu i- tion of the triad. Cardiac catheterization with contr t aortography and quantitation of the regurgitant f - tion is diagnostic (Figure 7).

The clinical impression that aortic regurgitation n be well compensated for a long period has been dem strated by several studies (Table). Bland and Whe r reported overall 10-year and 20-year survivals o almost 62 percent and 44 percent, respectively, am g 87 young people with rheumatic aortic regurgitatio 26 Rotman et al. found an 80 percent 2.8-year surv al among 29 unoperated patients in a surgical stud 15 Spagnuolo et al. defined a high-risk group of 31 a- tients with a 6-year survival of 71 percent and a l w- risk group of 72 patients with only a single death o r the same period by the presence or absence of the t d described above.[25] Rapaport reported 75 percent 5-y r and 50 percent 10-year survivals among 35 unselec d patients with chronic lesions.[7] The pooled data f m

TABLE

Natural History of Valvular Lesions

Aortic Regurgitation		Mitral Regurgitation	
Bland and Wheeler 1957[26]	Series of 87 children and adolescents with severe rheumatic regurgitation followed 10 to 20 years. Forty-six patients (1921-1931 series): Survivals of 76 percent, 61 percent, 50 percent, 43 percent at 5, 10, 15, 20 years. Forty-one patients (1931-1943 series): Survivals of 76 percent, 63 percent at 5, 10 years.	Wilson and Lim 1957[29]	Series of 392 patients with pure rheumatic regurgitation seen between 1916 and 1956, followed from age 20 years until death or the close of the study. Twelve deaths in the group (1 endocarditis, 11 "other"). Overall annual mortality rate over ages 20 to 52 years of 2.76/1000, not significantly different from the overall United States death rate for the same.
Rotman et al. 1971[15]	Surgical series with 29 medically treated patients. Survival of 80 percent at 2.8 years.	Rapaport 1957[7]	Series of 70 unselected patients with survivals of 80 percent at 5 years and 60 percent at 10 years. Series of 102 unselected patients with stenosis/regurgitation with survivals of 67 percent at 5 years and 33 percent at 10 years, worse than the pure regurgitation group.
Spagnuolo et al. 1971[25]	Series of 31 high-risk patients with 71 percent 6-year survival and 72 low-risk patients with 1 death in 6 years. Risk assigned by the presence or absence of a triad of left ventricular enlargement, electrocardiographic, and blood pressure abnormalities.	Munoz et al. 1975[22]	Surgical series with 99 symptomatic patients (29 pure regurgitation, 70 stenosis/regurgitation) treated medically. Forty-six percent 5-year survival.
Rapaport 1975[7]	Series of 35 unselected patients with survivals of 75 percent at 5 years and 50 percent at 10 years.	Hammermeister et al. 1978[30]	Series of 36 medically treated patients with survival probabilities of 54 percent at 5 years and 22 percent at 10 years.
Schwarz et al. 1982[17]	Surgical series with 28 medically treated patients. Eighty-seven percent 5-year survival.		

gnuolo et al. (high-risk group) and Rapaport are wn in Figure 2. The 5-year and 10-year survivals 76 percent and 62 percent, respectively. More re- ly, Schwarz et al. had a 5-year survival of 87 per- among 28 operative candidates who did not ergo surgery.[17]

ne problem in managing patients with chronic ic regurgitation is that they may develop ir- rsible myocardial damage severely jeopardizing fu- surgical therapy while remaining asymptomatic. ddition, they may develop a rapid downhill course e symptoms do occur. Guidelines for resolving the nma of surgical timing are discussed in the next ion.

RAL REGURGITATION

itral regurgitation is present when the left atrium ives backward flow from the left ventricle during ole. The etiology of clinically isolated, severe, nic, pure mitral regurgitation was reviewed by er et al. in 97 patients over the age of 30 years ergoing mitral valve replacement.[27] The etiology mitral valve prolapse in 62 percent, coronary ar- disease (papillary muscle dysfunction) in 30 per- , infective endocarditis on previously normal s in 5 percent, and rheumatic in 3 percent. Thus, etiology was nonrheumatic in 97 percent of the nts in this recent series, strongly supporting the ral consensus that rheumatic fever no longer is ajor cause of mitral regurgitation.

As with aortic regurgitation, mitral regurgitation presents the left ventricle with a chronic volume overload. Patients usually develop fatigue and an insidious loss of exercise capacity as early manifestations of congestive heart failure. Self-limitation of activity can further postpone the onset of symptoms. Eventually, dyspnea on exertion and then at rest is followed by frank failure. Onset of atrial fibrillation is the most common cause of sudden decompensation.[28] The physical findings include a parasternal lift due to left atrial expansion and a displaced, hyperdynamic left ventricle. The first heart sound is diminished (decreased M1) and there is a high-pitched, blowing, apical holosystolic murmur radiating to the axilla and back. This classical murmur was described primarily in association with rheumatic lesions. The murmur of mitral valve prolapse is midsystolic and that of coronary artery disease often is late systolic. An S3 gallop commonly is heard. The chest x-ray shows left atrial and ventricular enlargement and the electrocardiogram demonstrates left atrial abnormality and systolic or diastolic overload left ventricular hypertrophy. The echocardiogram also may reveal left atrial enlargement and a hyperdynamic left ventricle. Unlike the stenotic lesions of the aortic and mitral valves, the regurgitant lesions cannot be diagnosed on the basis of direct echocardiographic visualization; they must be inferred on the basis of indirect hemodynamic effects. Cardiac catheterization with left ventriculography demonstrating regurgitant flow in systole to the left atrium is

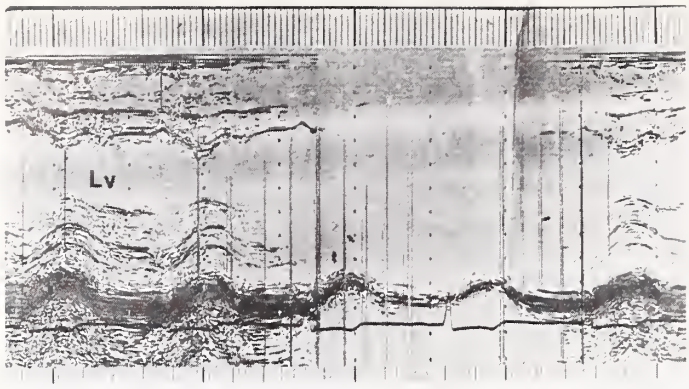


Figure 6—Left ventricular volume overload. This M-mode echocardiogram was obtained from a patient with chronic aortic regurgitation and demonstrates the appearance of left ventricular (LV) volume overload. The left ventricle is enlarged and hyperdynamic. A similar appearance is seen with chronic mitral regurgitation.

diagnostic (Figure 8).

Survival data for mitral regurgitation are presented in the Table. It should be emphasized that mitral regurgitation is not invariably progressive.[28] Due to the long clinical course during which cardiac compensation is maintained, there are less data available on the natural history of the disease. Kirkland and Pacifico, reviewing the natural history of mitral valvular disease in their surgical study, cited Olesen's data for mitral stenosis but could find "no comparable data for patients with mitral valvular incompetence" in 1973.[3] Wilson and Lim reported a series of 392 patients with pure rheumatic mitral regurgitation seen between 1916 and 1956. The patients were followed from 20 years of age until death or the close of the study. There were only 12 deaths in the group: one was attributed to infectious endocarditis and the remaining 11 to "other" noncardiac causes.[29] Rapaport reported 80 percent 5-year and 60 percent 10-year survival among 70 unselected patients with pure mitral regurgitation.[7] He also reported 67 percent 5-year and 33 percent 10-year survival, respectively, in a group of 102 unselected patients with combined mitral stenosis/regurgitation. Munoz et al. found a 46 percent overall 5-year survival in a group of 99 patients comprised of 29 pure and 70 mixed lesions.[22] Hammermeister et al. found survival probabilities of 54 percent and 22 percent at 5 years and 10 years, respectively, for a group of 36 medically treated patients.[30] Pooled data from the studies of Rapaport and Hammermeister et al. are shown in Figure 2; the 5-year survival is 69 percent and the 10-year survival is 41 percent.

Patients with mitral regurgitation, like their counterparts with aortic regurgitation, may develop irreversible myocardial damage during the asymptomatic phase of their disease. Due to favorable unloading of the left ventricle, patients with mitral regurgitation can sustain more cardiac dysfunction without decompensation. However, when decompensation necessitating surgical intervention does occur, the postoperative course is less favorable than that with aortic regurgitation.

PART 2

Part 2 will present recent surgical data and discuss the indications, timing, and hemodynamic implications of surgery.

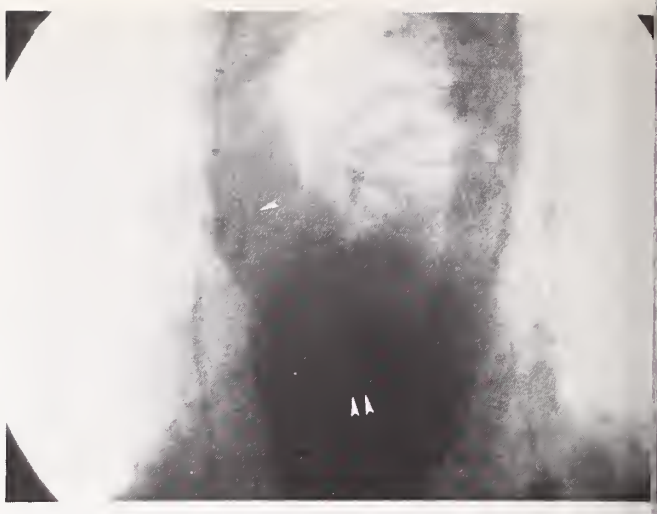


Figure 7—Aortic regurgitation. This figure illustrates an teriogram in the left anterior oblique projection. A pig catheter is present in the ascending aorta (single arr There is severe aortic regurgitation with greater opacifica of the left ventricular chamber (double arrow) than the ao

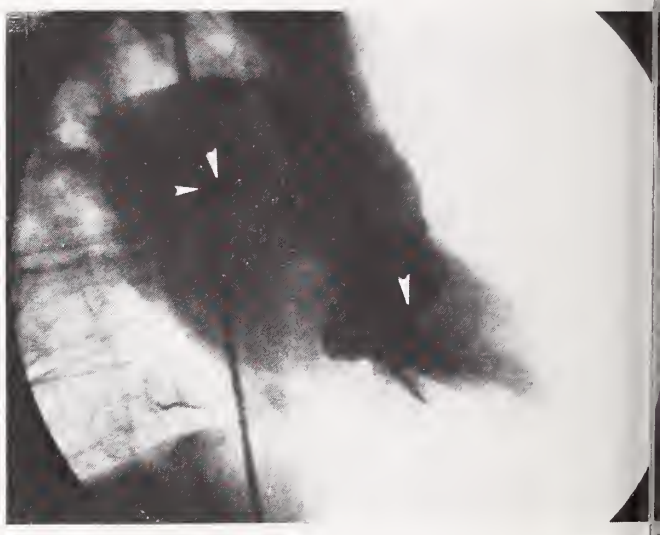


Figure 8—Mitral regurgitation. This figure illustrates a ventriculogram in right anterior oblique projection. A pi catheter is present in the left ventricle (single arrow). T is severe mital regurgitation due to mitral valve prolapse. left atrium (double arrow) is enlarged greatly and cont material can be seen refluxing into the pulmonary vei

REFERENCES

1. Harken DE, Soroff HS, Taylor WJ, Lefemine AA, Gu SK, Lunzer S: Partial and complete prostheses in aortic in ficiency. *J Thorac Cardiovasc Surg* 40:744-762, 1960.

2. Starr A, Edwards ML: Mitral replacement: Clinical perience with a ball-valve prosthesis. *Ann Surg* 154:726- 1961.

3. Kirklin JW, Pacifico AD: Surgery for acquired valv heart disease. *N Engl J Med* 288:133-140; 194-199, 19

4. Rahimtoola SH: Early valve replacement for the pre vation of function. *Am J Cardiol* 40:472-474, 1977.

5. Hammermeister KE: Chronic valvular disease adults—when to operate. *J Cardiovasc Med* 6:632-655, 1

6. Rahimtoola SH: Valve replacement should not be formed in all asymptomatic patients with severe aortic competence. *J Thorac Cardiovasc Surg* 79:163-172, 19

7. Rapaport E: Natural history of aortic and mitral v disease. *Am J Cardiol* 35:221-227, 1975.

8. Bogart DB, Murphy BL, Wong Bys, Pugh DM, Dunn Progression of aortic stenosis. *Chest* 76:391-396, 1979

9. Cheitlin MD, Gertz EW, Brundage BH, Calson CJ, Gu JA, Bode RS: Rate of progression of severity of valvular a

nosis in the adult. *Am Heart J* 98:689-700, 1979.
0. Wagner S, Selzer A: Patterns of progression of aortic nosis: A longitudinal hemodynamic study. *Circulation* 709-712, 1982.
1. Ross J Jr, Braunwald E: Aortic stenosis. *Circulation* 38: pl V:V61-V67, 1968.
2. Bergeron J, Abelman WH, Vazquez-Milan H, Ellis LB: tic stenosis-clinical manifestations and course of the dis-e. *Arch Intern Med* 94:911-924, 1954.
3. Wood P: Aortic stenosis. *Am J Cardiol* 1:533-571, 1958.
4. Takeda J, Warren R, Holzman D: Prognosis of aortic nosis. *Arch Surg* 87:931-963, 1963.
5. Rotman M, Morris JJ Jr, Behar VS, Peter RH, Kong Y: tic valvular disease. *Am J Med* 51:241-257, 1971.
6. Frank S, Johnson A, Ross J Jr: Natural history of ular aortic stenosis. *Br Heart J* 35:41-46, 1973.
7. Schwarz F, Bauman P, Manthey J, Hoffman M, Schuler Mehmel H, Schmitz W, Kubler W: The effect of aortic valve acement on survival. *Circulation* 66:1105-1110, 1982.
8. Selzer A, Cohn KE: Natural history of mitral stenosis: eview. *Circulation* 45:878-890, 1972.
9. Matthews MB, Medd WE, Gorlin R: Aortic stenosis: A ical study. *Br Med J* 2:759-763, 1955.
0. Rowe JC, Bland EF, Sprague HB, White PD: The course nitral stenosis without surgery. Ten- and 20-year per-ctives. *Ann Intern Med* 52:741-749, 1960.
1. Olesen KH: The natural history of 271 patients with ral stenosis under medical treatment. *Br Heart J* 24:349-357, 1962.
22. Munoz S, Gallardo J, Diaz-Gorrin JR, Medina O: Influence of surgery on the natural history of rheumatic mitral and aortic valve disease. *Am J Cardiol* 35:234-242, 1975.
23. Goldschlager N, Pfeifer J, Cohn K, Popper R, Selzer A: The natural history of aortic regurgitation. *Am J Med* 54:577-588, 1973.
25. Spagnuolo M, Kloth H, Taranta A, Doyle E, Pasternack B: Natural history of aortic regurgitation. *Circulation* 44:368-380, 1971.
26. Bland EF, Wheeler EO: Severe aortic regurgitation in young people. *N Engl J Med* 256:667-672, 1957.
27. Waller BF, Morrow AG, Maron BJ, Del Negro AA, Kent KM, McGrath FJ, Wallace RB, McIntosh CL, Roberts WC: Etiology of clinically isolated, severe, chronic, pure mitral regurgitation: Analysis of 97 patients over 30 years of age having mitral valve replacement. *Am Heart J* 104:276-288, 1982.
28. Selzer A, Katayama F: Mitral regurgitation: Clinical patterns, pathophysiology, and natural history. *Medicine* 51:337-366, 1972.
29. Wilson MG, Lim WN: The natural history of rheumatic heart disease in the third, fourth, and fifth decades of life. *Circulation* 16:700-712, 1957.
30. Hammermeister KE, Fisher L, Kennedy JW, Samuels S, Dodge HT: Prediction of late survival in patients with mitral valve disease form clinical, hemodynamic, and quantitative angiographic variables. *Circulation* 57:341-349, 1978.

Just once each day...

First-step blood pressure control with optimal simplicity

Benefits diuretics cannot offer... Once-daily INDERAL LA (propranolol hydrochloride) with its smooth 24-hour control of blood pressure provides a high degree of patient acceptance without potassium problems, plus the cardiovascular benefits of the world's leading beta blocker.

Experience no other beta blocker can match... Once-daily INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.



Start with 80 mg once daily... Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



80 mg 120 mg 160 mg

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories

Just once each day for initial therapy in hypertension.

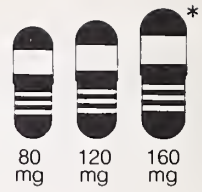
Ayerst

Just once each day for initial therapy in HYPERTENSION.

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL* LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking th prior to major surgery is controversial. It should be noted, however, that the impaired ab the heart to respond to reflex adrenergic stimuli may augment the risks of general anes and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of receptor agonists and its effects can be reversed by administration of such agents dobutamine or isoproterenol. However, such patients may be subject to protracted hypotension. Difficulty in starting and maintaining the heartbeat has also been reporte beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent th pearance of certain premonitory signs and symptoms (pulse rate and pressure chang acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyro Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of sym of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have reported in which, after propranolol, the tachycardia was replaced by a severe brady requiring a demand pacemaker. In one case this resulted after an initial dose of propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with im hepatic or renal function. INDERAL is not indicated for the treatment of hypert emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. P should be told that INDERAL may interfere with the glaucoma screening test. Withdraw lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart di elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as pine should be closely observed if INDERAL is administered. The added catechol blocking action may produce an excessive reduction of resting sympathetic nervous which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orth hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animal been conducted to evaluate toxic effects and carcinogenic potential. In 18-month stu both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of sign drug-induced toxicity. There were no drug-related tumorigenic effects at any of the levels. Reproductive studies in animals did not show any impairment of fertility th attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryot animal studies at doses about 10 times greater than the maximum recommended human There are no adequate and well-controlled studies in pregnant women. INDERAL be used during pregnancy only if the potential benefit justifies the potential risk to the

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercise INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established
ADVERSE REACTIONS. Most adverse effects have been mild and transient and rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block tension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usuall Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by ins lassitude, weakness, fatigue; reversible mental depression progressing to catatonia disturbances; hallucinations; an acute reversible syndrome characterized by disorienta time and place, short-term memory loss, emotional lability, slightly clouded sensoriu decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, di constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocyt purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus ha reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male tence, and Peyronie's disease have been reported rarely. Oculomucocutaneous re involving the skin, serous membranes and conjunctivae reported for a beta blocker (pr have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochlor sustained-release capsule for administration once daily. If patients are switched from IN tablets to INDERAL LA capsules, care should be taken to assure that the desired ther effect is maintained. INDERAL LA should not be considered a simple mg for mg subst INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitrati be necessary especially to maintain effectiveness at the end of the 24-hour dosing i

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is INDERAL LA once daily, whether used alone or added to a diuretic. The dosage increased to 120 mg once daily or higher until adequate blood-pressure control is ac The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosag mg may be required. The time needed for full hypertensive response to a given do variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDE once daily, dosage should be gradually increased at three to seven day intervals until o response is obtained. Although individual patients may respond at any dosage le average optimum dosage appears to be 160 mg once daily. In angina pectoris, the va safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDE once daily. The usual effective dose range is 160-240 mg once daily. The dosage increased gradually to achieve optimum migraine prophylaxis. If a satisfactory respons obtained within four to six weeks after reaching the maximum dose, INDERAL LA should be discontinued. It may be advisable to withdraw the drug gradually over a p several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.
PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Labo

89

Ayerst AYERST LABORATORIES
New York, N.Y. 10017

NDIUM-111-OXINE-LABELED EUKOCYTE IMAGING

RED M. PALACE, M.D., AND RAYMOND F. CRYSTAL, M.D., MORRISTOWN*

n the postoperative period, it is difficult to determine the location of an inflammatory process for purpose of drainage. Fifteen patients participated in a study in which injection of the patient's own white blood cells labeled with indium-111-oxine was used to demonstrate localized foci of inflammation.

In the evaluation of the patient who has developed signs and symptoms of infection after abninal surgery, a surgeon has few effective modalities diagnosis. A chest x-ray, a urinalysis, and an evaluon of the incision for infection are utilized.

T scanning as the first step in screening is not cost ctive. It is most helpful when a relatively small area o be scanned, since individual tomographic slices n the diaphragm to the pubis at centimeter inters are high in cost, high in radiation, and low in ds.[1] It is difficult, if not impossible, to differentiate ween a noncontrast filled bowel loop and an abscess these computer-created images.

ltrasonography also is limited in value by the fact t postoperative patients show a reactive (adynamic) is and bowel gas is an effective barrier to ultraographic evaluation. Scanning the patient after an ravenous injection of gallium 67 has been used for poses of localization of an abscess. Disadvantages (1) the slow nature of the procedure, i.e. gallium st clear the soft tissues before localization of an cess can be made, usually in 36 to 48 hours; (2) the terial is excreted through the gastrointestinal tract l therefore the colon (especially the right colon) is ualized unless massive efforts to cleanse the colon made; and (3) radiogallium is taken up in the ural line itself (probably by histiocytes there).

new modality of diagnosis now is available—injection of the patient's own indium-111-oxine-labeled white blood cells (WBC). This technique can be used to localize foci of inflammation and infection.

METHODS

Fifteen patients at Morristown Memorial Hospital participated in a phase III clinical evaluation of indium-111-oxine-labeled WBC as approved by the Hospital's Institutional Review Board. Fifty cc of blood was withdrawn in a heparin-coated syringe and sent to a commercial laboratory** where the patient's WBC were labeled using a technique approved by the Amersham Corporation and the Food and Drug Administration.[9] The tagged WBC (containing approximately 500 uc of radioindium) were returned to the hospital within three hours; the patient was injected with these cells and imaging of the patient was performed 4 to 18 hours later using either a 61 tube (General Electric) Maxicamera or a 37 tube Gamma Camera (Picker Corporation). Images to include the top of the head down to below the hips in both the anterior and posterior positions were taken. The extremities were imaged if

*Dr. Palace is Chief, Section of Nuclear Medicine, and Dr. Crystal is Attending Surgeon, Colon-Rectal Surgery, Morristown Memorial Hospital. Correspondence may be addressed to Dr. Palace, Morristown Memorial Hospital, 100 Madison Avenue, Morristown, NJ 07960.

**Syncor, Inc., Fairfield, NJ.

clinically indicated and 300,000 counts per image were collected. The following are representative case histories.

CASE REPORT 1

A 72-year-old female was hospitalized with dyspnea requiring intubation, ventilator support, and steroid therapy. Ten days later, she underwent antrectomy, vagotomy, and gastroduodenostomy for a bleeding duodenal ulcer. The bleeding persisted postoperatively and a subtotal gastrectomy and gastrojejunostomy were performed. Three days later, she developed pneumonitis which was treated with tobramycin and clindamycin intravenously. In spite of antibiotics, she maintained a persistent temperature elevation to 38.6°C and a leukemoid reaction with WBC count of 44,800. Gallium scanning showed increased uptake in the left lung (consistent with the patient's left lower lobe pulmonary infiltrate) and increased uptake in the left flank (Figure 1). CT scan of the abdomen (after oral and intravenous contrast material) demonstrated no abnormal collections. Indium-111 WBC study one week later demonstrated abnormal uptake in both lower lobes and throughout the entire colon (Figure 2). By this time the patient developed diarrhea and was passing ten liquid stools per day. The stool culture was negative for salmonella, shigella, and other enteric pathogens. Three stools were positive for *Clostridium difficile* toxin. Colonoscopy to 50 cm revealed multiple whitish plaques throughout, consistent with pseudomembranous colitis. Treatment with vancomycin was begun and within one week the diarrhea had stopped and the patient's WBC count had fallen to 13,600.

This seriously ill elderly patient, who received a number of antibiotics including clindamycin, was at high risk for the development of pseudomembranous colitis. Nevertheless, various symptoms and signs (diarrhea, abdominal pain, fever, leukocytosis, and, in some cases, megacolon) may make diagnosis difficult, particularly in patients who have undergone gastrointestinal surgery.[2] Traditionally, the most reliable diagnostic tools were considered to be the proctoscopic examination, barium contrast study of the colon, and biopsy.[3]

The indium-labeled WBC scan may evaluate patients rapidly (six hours) with an acute abdomen which is fulminant and in which intubation of the colon or the hydrostatic pressure of an enema may be hazardous, and with colitis which may be differentiated from other causes of diarrhea by a noninvasive method because of the severity and extent of the inflammation. The indium-labeled WBC scan also is an accurate method for assessing the patient with acute ulceration and Crohn's disease.[4]

CASE REPORT 2

An 82-year-old white female underwent Hartmann resection of the left colon with a distal transverse colostomy on May 8, 1983, for acute and chronic diverticulitis with partial colonic obstruction. Postoperatively, she developed a wound infection due to *Pseudomonas aeruginosa*, *E. coli*, and enterococcus. On May 23, 1983, an indium-111-labeled WBC scan

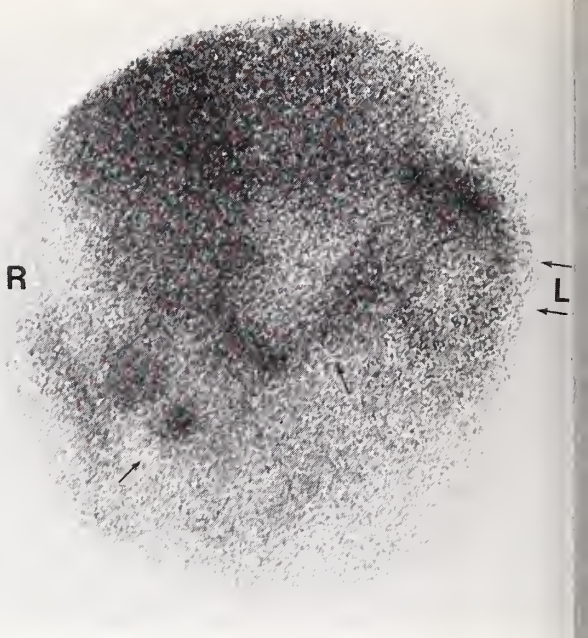


Figure 1—Anterior view of abdomen, gallium scan. Note g lium uptake in the liver and colon as usually seen (case re 1).

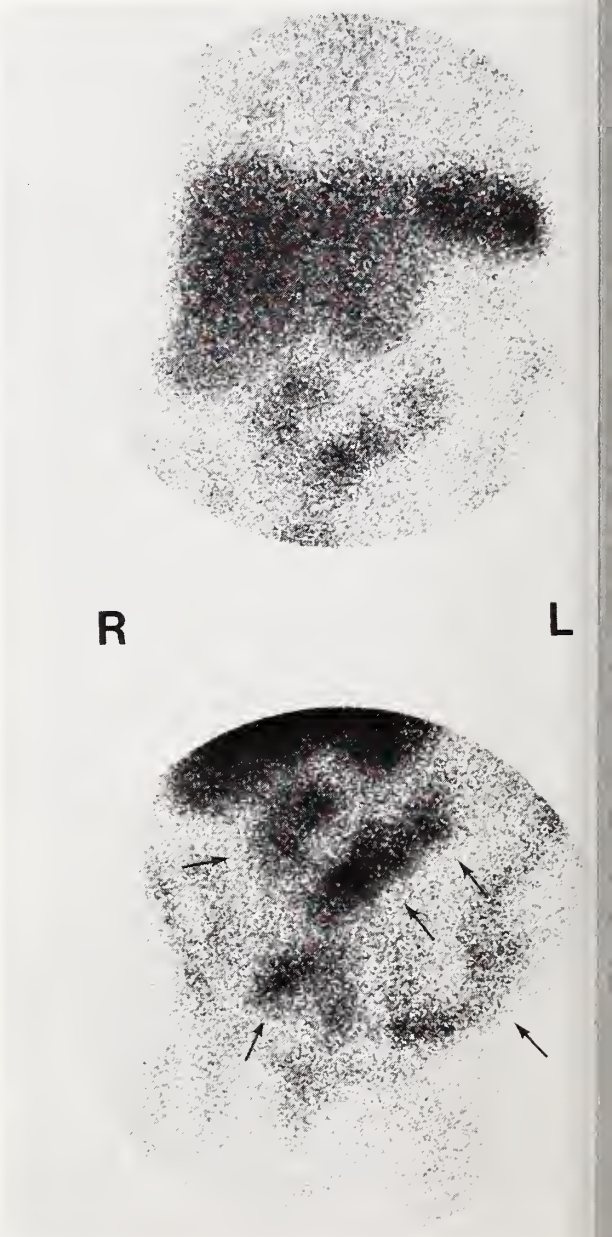
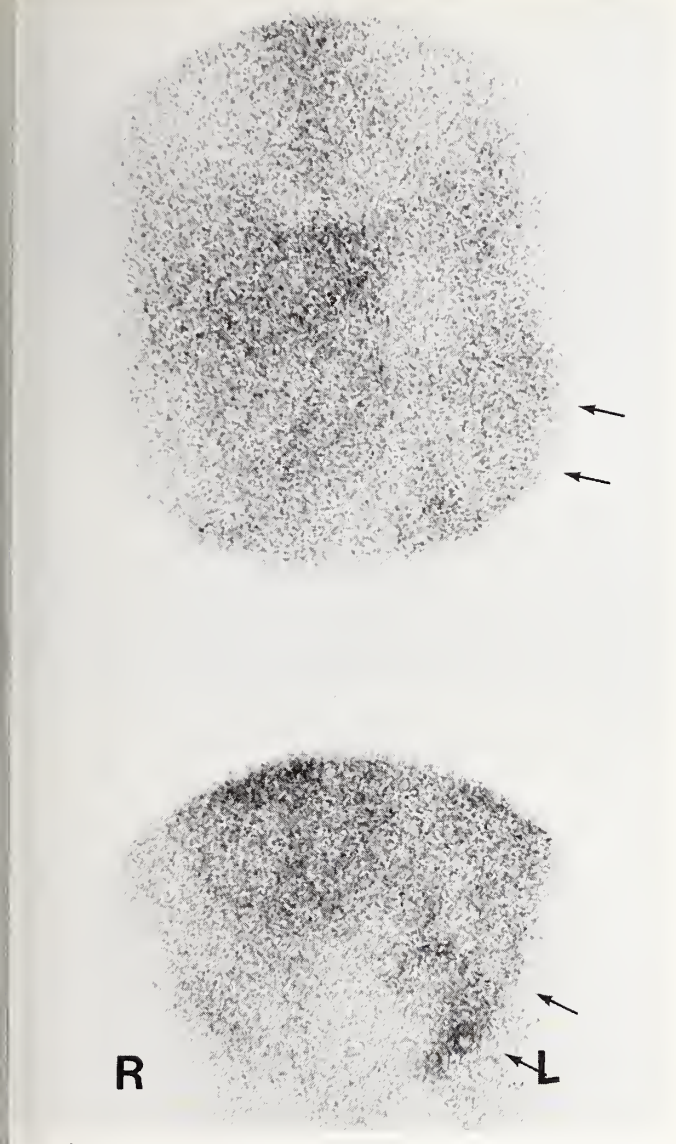


Figure 2—Anterior view of abdomen and pelvis, inc study. Note normal uptake in the liver and spleen and normal uptake in the colon demonstrating the pseudor branous colitis (case report 1).



gure 3—Anterior view gallium scan (48 hours) demonstrating the abnormal (but weak) uptake in the left lower quadrant ase report 2).

as performed. An abnormal collection of radionuclide nsistent with a large abscess was seen in the left teral abdomen extending from the inferior margin of e spleen into the pelvis. There also was abnormally creased uptake of radionuclide extending from the phoid to the pubis consistent with an infected mide abdominal incision. On May 26, 1983, a barium iema study through the colostomy demonstrated a rge abscess cavity in the left gutter which filled with arium presumably through a fistulous communicaon. A sump drain was placed in this abscess cavity d cultures grew *Pseudomonas* and *E. coli* (Figures to 6).

Intra-abdominal abscess following colonic surgery is t rare. In a study of 231 consecutive colonic operions, four patients developed intra-abdominal scesses.[5] Unrecognized and untreated, intra-abominal abscesses may lead to additional complicaons and death. Identification and localization of such abscess by a noninvasive technique is highly derable yet not always easily accomplished. The acuracy of indium-labeled WBC scan for this purpose as been well documented.[6] A particular benefit of ich a noninvasive test is its ability to identify the umber of purulent collections in a particular patient.



Figure 4—Anterior view (18 hours) indium scan. Note abnormal uptake in the suture line and in the left lower quadrant representing the fistula and normal uptake in the liver and spleen (case report 2).

This information may affect the choice between surgical and percutaneous drainage.[7]

CASE REPORT 3

A 26-year-old white female, whose Crohn's disease was first diagnosed at age 13, underwent resection of the terminal ileum and cecum at age 17. She subsequently had recurrent exacerbations of weight loss, fever, anorexia, and diarrhea. In July 1982, the diagnosis of pregnancy was associated with fever, 18 to 20 pound weight loss, pain in the right lower quadrant, and a mass. Sigmoidoscopy revealed many shallow serpiginous ulcers of the mucosa of the rectum. In November 1982, she was admitted to Morristown Memorial Hospital and the preganancy was terminated. A small bowel x-ray study showed a collection of barium, within an abscess cavity in the right upper quadrant, believed to have extravasated through a fistulous tract from the small bowel. There was complete involvement of the large bowel with what appeared to be granulomatous colitis. On November 30, she underwent a diverting ileostomy and drainage of a right retroperitoneal abscess. Postoperatively she was

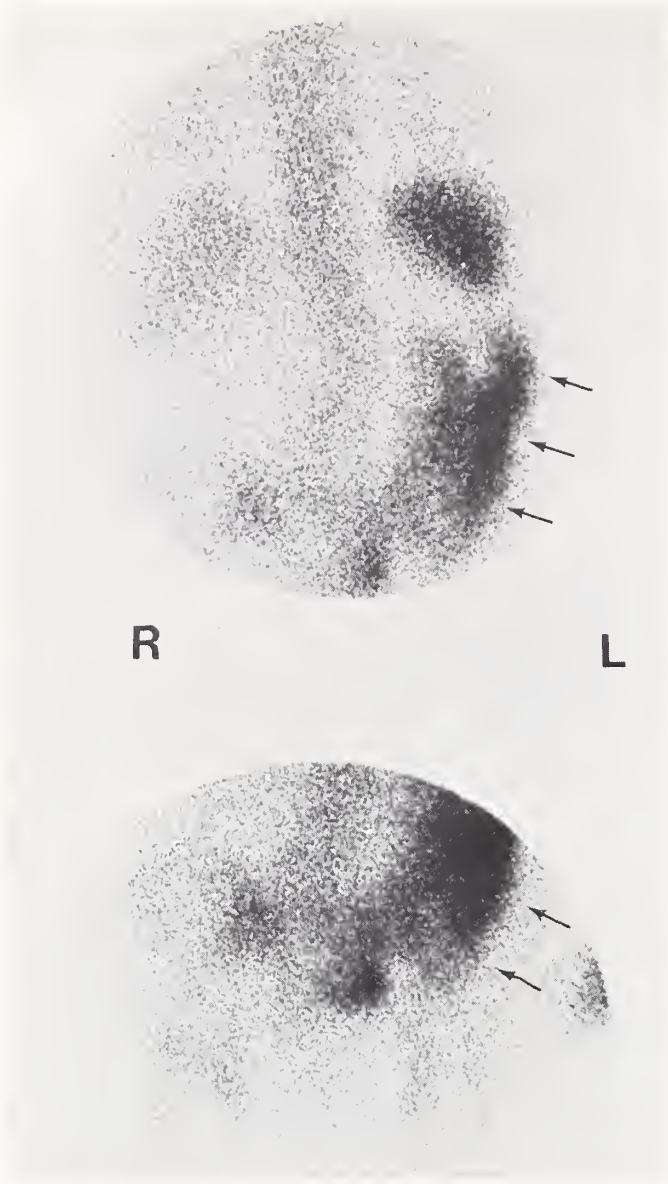


Figure 5—Posterior view of indium study showing large intra-abdominal and intrapelvic abscess (case report 2).



Figure 6—Anterior-posterior view of barium enema illustrating a catheter in the colostomy and contrast material filling the peritoneal abscess (case report 2).

treated with clindamycin and tobramycin and was afebrile until December 6, 1982, when her temperature rose to 38.3°C. Progressive anemia required transfusion of nine units of packed cells between December 4 and December 9. She had recurrent fever and on December 21, 1982, an indium-labeled WBC scan showed abnormal uptake in multiple loops of small bowel in the right mid-epigastrium consistent with an active granulomatous process (Figure 7). A huge area of abnormal uptake filled much of the left side of the pelvis, and extended up to the spleen. This was thought to represent phlegmon or abscess involving the distal descending colon and rectosigmoid. White blood count at that time was 16,500. CT scan of the abdomen demonstrated a large mass of loculated fluid, thought to represent the phlegmon as previously described (Figures 8 and 9). A barium enema through the rectum demonstrated the devitalized colon to be appropriately narrow so that the abnormal uptake on the indium scan and the CT study could not represent an inflamed colon. On December 23, 1982, the patient underwent an incision and drainage of an infected intraperitoneal hematoma. By January 5, 1983, she was afebrile with a pulse of 80 and a white blood count of 10,600. A subsequent indium-labeled study showed resolution of the abdominal/pelvic mass previously described but the abnormal small bowel and colonic uptake remained.

This case demonstrates a variety of radiological modalities used to diagnose intra-abdominal and retroperitoneal abscesses. The first abscess was demonstrated by a small bowel series, which confirmed a fistulous connection between the bowel and abscess cavity. An infected hematoma was first localized by the indium study and further documented by the CT study. The resolution of the abscess was well demonstrated by repeat indium scanning which also demonstrated that the tagged leukocytes will be taken up by an actively inflamed colon. This principle has been applied to the differentiation of the pancreatic abscess from pancreatic pseudocyst using indium-111-labeled leukocytes (Figures 7 to 9).[8]

DISCUSSION

Indium-111-autologous white blood cells have been used for localization of abscesses, fistulae, and osteomyelitis for many years first having been used for this purpose in 1976.[9] The radionuclide is deposited wherever white cells are sequestered which explains the distribution of the radioindium in the bone marrow, in the liver, and in the spleen. Areas of focal infection usually are demonstrated well. The material usually is not deposited in normal bowel and has been shown to have clinical utility in the evaluation of patients with granulomatous and ulcerative bowel disease.[4] False positive studies are found in cases of swallowed leukocytes (e.g. sinusitis, rhinitis, endotrachial tubes, nasogastric tubes), accessory spleens and transplant rejections.[10]

False negative studies occur in patients with long-standing abscesses which perhaps do not have an adequate blood supply and, therefore, lack a mechanism for the white cells to be sequestered there. Similarly in an area of osteomyelitis where the periosteum is tightly adherent and where there is a choking off of



igure 7—Anterior view of abdomen and pelvis indium study 18 hours). Note abnormal uptake in the left lower quadrant epresenting the infected hematoma. Note abnormal uptake ight lower quadrant representing abnormal small bowel (re- ional enteritis) (case report 3).



Figure 8—Initial image of CT scan demonstrating contrast material in the defunctionalized colon (case report 3).

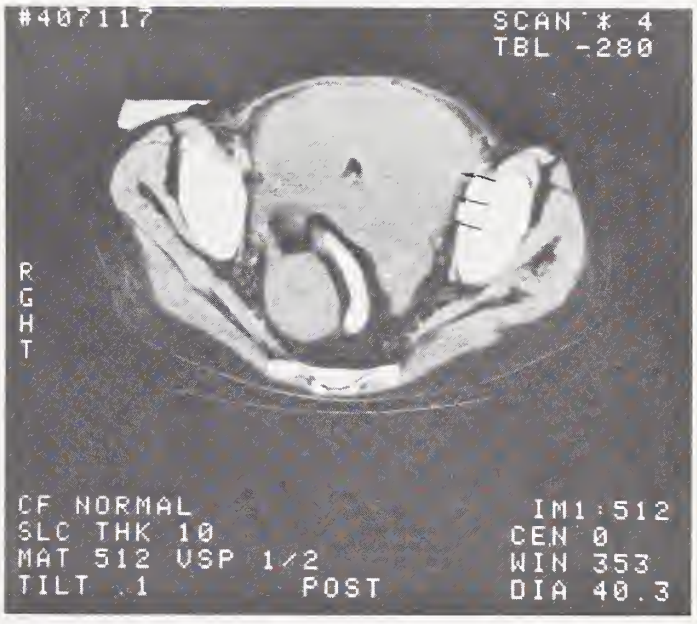


Figure 9—Pelvic CT scan demonstrating huge pelvic mass subsequently drained (case report 3).

ıe blood supply, there is an occasional false negative tudy. The sensitivity and specificity of the indium tudy is reported to be 95 percent and 97 percent, spectively.[11]

Indium-111-WBC imaging is at least as sensitive as allium in imaging and has far greater specificity due the fact that there is no normal bowel uptake, which gallium's major disadvantage. This study will be of ignificant aid to the physician in the evaluation of atients with occult inflammatory disease especially hen many of the paperwork obstacles to wider utiliza- on have been relieved.

EFERENCES

1. Karsell PR II, O'Connell MJ: Computer tomography in earch of cancer of unknown origin. *JAMA* 248.340-343, 982.

2. Dowel VR Jr: Antibiotic associated colitis. *Hosp Prac* 75. 979.

3. Tedesco FJ, Stanley RJ, Alpers DH: Diagnostic features of clindomycin-associated pseudomembranous colitis. *N Engl J Med* 290.841, 1974.

4. Stein DT, Gray GM, Gregory PB, Anderson M, Goodwin DA, McDougall IR: Location and activity of ulceration and Crohn's colitis by indium 111 leukocyte scan. *Gastroenterology* 84:388-393, 1983.

5. Crystal RF, Chang P: The surgeon, the surgery, the patient, and the disease; factors complicating colonic surgery. *Ann Surg* 181:9-14, 1975.

6. Coleman RE, Black RE, Welch DM, Maxwell JG: Indium-111-labeled leukocytes in the evaluation of suspected abdominal abscesses. *Am J Surg* 118:273, 1983.

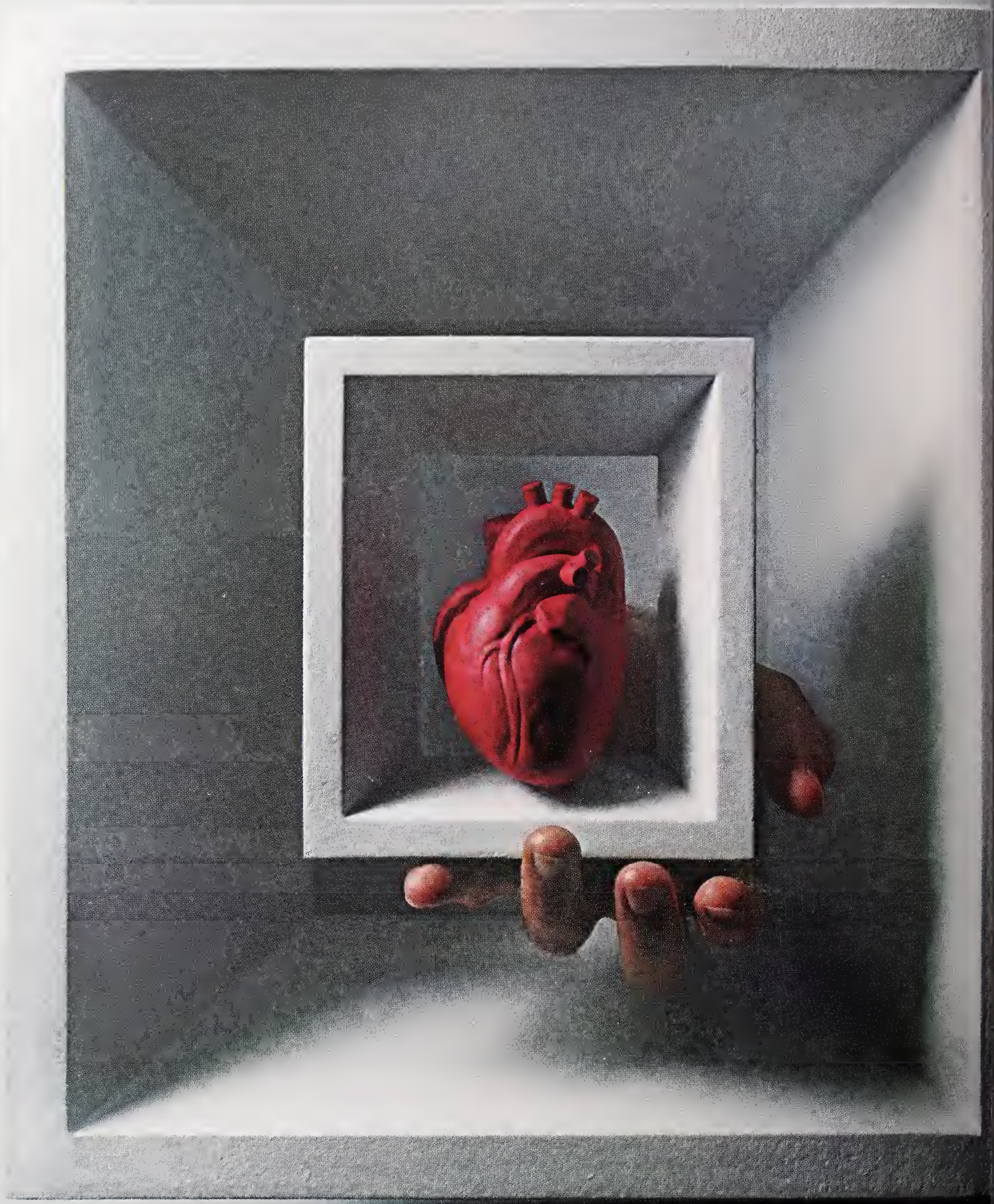
7. Aeder MI, et al.: Role of surgical and percutaneous drainage in the treatment of abdominal abscesses. *Arch Surg* 118:273, 1983.

8. Bicknell TA, Kohatsu, S, Goodwin DA: Use of indium-111-labeled autologous leukocytes in differentiating pancreatic abscess from pseudocyst. *Am J Surg* 142:312, 1981.

9. Siegel AW, Arnot RN, Thakur ML, et al: Indium-111-labeled leukocytes for localization of abscesses. *Lancet* 2:1056, 1976.

10. Coleman, RE, Walsh, E: Possible pitfalls with clinical imaging of indium-111-leukocytes; concise communication. *J Nucl Med* 21:122, 1980.

11. McDougal IR, Goodwin DA: Editor's correspondence. *Arch Int Med* 142.1407, 1982.



Angina Protection with Benefits for a Lifetime

ONCE-DAILY CONTROL WITH HEART-SAVING BENEFITS

By reducing heart rate and cardiac contractility, INDERAL LA helps protect the heart from the potentially serious and debilitating consequences of ischemia. A highly effective antianginal agent for around-the-clock control of symptoms, INDERAL LA also provides cardiovascular protection for a sense of security in the years ahead.

PROTECTION AND EXPERIENCE NO CALCIUM BLOCKER CAN MATCH

Unlike calcium blockers, INDERAL LA—either alone or with a nitrate—is recommended for early treatment of angina in the majority of patients. Equally important, INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use.

START WITH 80 MG ONCE DAILY

Dosage may be increased to 160 mg once daily, as needed, to achieve optimal control. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY **INDERAL® LA** (PROPRANOLOL HCl) LONG ACTING CAPSULES



Ayerst®

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

JUST ONCE EACH DAY FOR SIMPLIFIED CORE THERAPY IN ANGINA

ONCE-DAILY

INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking th prior to major surgery is controversial. It should be noted, however, that the impaired ab the heart to respond to reflex adrenergic stimuli may augment the risks of general anest and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of receptor agonists and its effects can be reversed by administration of such agents dobutamine or isoproterenol. However, such patients may be subject to protracted s hypotension. Difficulty in starting and maintaining the heartbeat has also been reporte beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent th pearance of certain premonitory signs and symptoms (pulse rate and pressure chang acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroi Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symp of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have reported in which, after propranolol, the tachycardia was replaced by a severe brady requiring a demand pacemaker. In one case this resulted after an initial dose of propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with imp hepatic or renal function. INDERAL is not indicated for the treatment of hyperte emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Pa should be told that INDERAL may interfere with the glaucoma screening test. Withdrawa lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart dis elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as pine should be closely observed if INDERAL is administered. The added catechola blocking action may produce an excessive reduction of resting sympathetic nervous a which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthc hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals been conducted to evaluate toxic effects and carcinogenic potential. In 18-month stuc both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of sign drug-induced toxicity. There were no drug-related tumorigenic effects at any of the d levels. Reproductive studies in animals did not show any impairment of fertility tha attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotc animal studies at doses about 10 times greater than the maximum recommended human

There are no adequate and well-controlled studies in pregnant women. INDERAL s be used during pregnancy only if the potential benefit justifies the potential risk to the

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block; tension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insc lassitude, weakness, fatigue; reversible mental depression progressing to catatonia, disturbances; hallucinations; an acute reversible syndrome characterized by disorientat time and place, short-term memory loss, emotional lability, slightly clouded sensorium decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, dia constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with a and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytc purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male tence, and Peyronie's disease have been reported rarely. Oculomucocutaneous rea involving the skin, serous membranes and conjunctivae reported for a beta blocker (pra have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochlorid sustained-release capsule for administration once daily. If patients are switched from IND tablets to INDERAL LA capsules, care should be taken to assure that the desired thera effect is maintained. INDERAL LA should not be considered a simple mg for mg substit INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitratic be necessary especially to maintain effectiveness at the end of the 24-hour dosing in

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is INDERAL LA once daily, whether used alone or added to a diuretic. The dosage m increased to 120 mg once daily or higher until adequate blood-pressure control is ach The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage mg may be required. The time needed for full hypertensive response to a given dos variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDER once daily, dosage should be gradually increased at three to seven day intervals until op response is obtained. Although individual patients may respond at any dosage lev average optimum dosage appears to be 160 mg once daily. In angina pectoris, the valu safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDER once daily. The usual effective dose range is 160-240 mg once daily. The dosage m increased gradually to achieve optimum migraine prophylaxis. If a satisfactory respons obtained within four to six weeks after reaching the maximum dose, INDERAL LA t should be discontinued. It may be advisable to withdraw the drug gradually over a pe several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Labor

883 8

Ayerst AYERST LABORATORIES
New York, N.Y. 10017

Pharmacological Basis of Therapeutics: Insulin-Like Growth Factors*

Margaret A. Brostrom, Ph.D., Piscataway**

Insulin and the insulin-like growth factors IGF-I and IGF-II belong to a family of growth-promoting polypeptides that share a considerable degree of structural similarity. Members of the family of insulin-like growth factors have their own receptors but some polypeptides crossreact with receptors for other family members.

Insulin and insulin-like growth factors belong to a family of biologically active growth-promoting polypeptides that share a considerable degree of similarity in primary and secondary structure and may have a common evolutionary origin.[1] This family includes insulin-like growth factor I (IGF-I) which also is called somatomedin C and is homologous to proinsulin, insulin-like growth factor II (IGF-II) which also is homologous to proinsulin, relaxin, and the more distant relative, nerve growth factor. These factors are single chain polypeptides of 7,000 to 9,000 molecular weight; they are acid-soluble, acid and heat stable, and inactivated by thiols.[2] IGF-I and IGF-II are identical at 45 of 73 amino acid positions examined. Both factors have been isolated from human plasma, liver, and liver-derived cells and are bound in serum apparently by a complex carrier system.[3] Concentrations of IGF-I and IGF-II in human plasma appear to be regulated by growth hormone in accord with the hypothesis that these substances serve as mediators of growth hormone action. Like insulin, both substances stimulate glucose oxidation and lipogenesis in adipose tissue; stimulations, however, are not affected by antibodies to insulin and are much smaller than those produced by insulin.[2] In cartilage, these factors enhance sulfate incorporation into glycosaminoglycans; in cartilage, muscle, and fibroblasts, they stimulate RNA, DNA, and protein synthesis; and, when applied to certain cultured cell types they promote cell multiplication. Many of the actions previously attributed to growth hormone now are recognized to be mediated by IGF-I and IGF-II.[4] Thus, a role for these factors in the control of growth is favored strongly by the available evidence.

It has been proposed that insulin, IGF-I, and IGF-II exert their metabolic effects via insulin receptors and their growth-promoting effects through IGF receptors.[5] Knowledge regarding insulin and IGF receptors recently has been reviewed.[6] Each insulin-like factor has its own receptor but some polypeptides crossreact with lower affinity with receptors for the other polypeptides. IGF-I, for example, binds to the receptor for IGF-II with a relatively high affinity, and vice versa. In contrast, both peptides bind to the insulin receptor with low affinity. Insulin binds to the IGF-I receptor with poor

*This article, fifth in a series, prepared under the leadership of Bruce McL. Breckenridge, M.D., Chairman, Department of Pharmacology, UMDNJ-Rutgers Medical School, is a brief review of recent advances in pharmacology and related preclinical sciences which will help readers to understand the actions of new and established therapeutic agents. The reviews do not consider indications for specific drugs, incompatibilities, or dosage forms, which can be found in the *AMA Drug Evaluations, 5th Edition*, 1983.

**From the Department of Pharmacology, UMDNJ-Rutgers Medical School. Correspondence may be addressed to Dr. M. Brostrom, UMDNJ-Rutgers Medical School, P.O. Box 101, Piscataway, NJ 08854.

affinity and has little or no affinity for the IGF-II receptor. Proinsulin has a weak affinity for the relaxin receptor. Such findings imply similarities among receptors for insulin-like factors, and similarities indeed have been found. Receptors for IGF-I and IGF-II have been identified and characterized. The IGF-I receptor has a subunit structure which is remarkably similar to that of the insulin receptor. It is a glycoprotein of approximately 350 killidaltons and, when subjected to electrophoresis without prior reduction, high molecular weight species with mobilities similar to unreduced forms of insulin receptors are observed. After complete reduction, a species of 135 killidaltons, which corresponds to the α subunit of the insulin receptor, is present. In some studies, a second species of 90 killidaltons has been observed; this species corresponds to the β subunit of the insulin receptor. The β subunits of both receptors, in contrast to their α subunits, are only weakly labeled in affinity labeling studies. The IGF-I receptor, like the insulin receptor, has been shown to exist as a disulfide-linked heterotetramer with a subunit structure $(\alpha\beta)_2$. Monoclonal antibodies have been produced which recognize preferentially either insulin receptors or IGF-I receptors.[6] However, each antibody crossreacts with both receptors showing clearly that the two receptors are related immunologically.

The IGF-II receptor appears structurally to be somewhat different from both the insulin receptor and the IGF-I receptor. Studies are consistent with a single polypeptide that is not linked through disulfide bonds to other membrane proteins. The IGF-II receptor has a molecular weight of approximately 260,000 and appears to be held together by intrachain disulfide bonds. Investigators in the field are puzzled as to why IGF-II receptors should be so different. However, a 200,000 molecular weight peptide, labeled by prior exposure of cells possessing insulin receptors to radioactive amino acid and precipitated by antibody to the insulin receptor, has been identified and hypothesized to be a biosynthetic precursor of the insulin receptor.[7] It is possible that proteolytic processing of this precursor could generate the α and β subunits. If this is the case, then the 200 killidalton precursor would be homologous to the single polypeptide IGF-II receptor which would possess α and β subunits in a single linear sequence. The insulin and IGF-I receptors are anticipated to undergo posttranslational modifications through which two precursor molecules would be linked by disulfide bonds and then cleaved to generate a tetramer. By contrast, the IGF-II receptor is expected to be resistant to such post-translational processing.

Extensive experimentation into the mechanism of insulin action[6,8,9] indicates that occupation of insulin receptors may result in (a) phosphorylation of tyrosine residues on the receptor through the activation of a protein kinase intimately associated with the receptor, (b) generation via proteolytic events of a chemical mediator, (c) receptor-mediated internalization of insulin, and (d) receptor "down-regulation." Whether comparable events follow the binding of IGF-I or IGF-II to their specific receptors remains to be demonstrated.

Two published studies are consistent with the concept that alterations in insulin-like growth factor concentrations occur during disease. In one study, serum concentrations of IGF-I and IGF-II were determined for 80 adult patients with diabetes and 6 control subjects. The rationale for conducting the study was the long-recognized association of pituitary growth hormone with the development of diabetic retinopathy, thickening of capillary basement membranes, and microvascular complications. Concentrations of IGF-I in serum from patients with type I (insulin-dependent) diabetes were significantly higher than normal and higher than serum concentrations of this factor in type II (noninsulin-dependent) diabetes. The serum concentrations of IGF-II, however, did not appear to be altered in type I disease and were lower than normal in type II diabetes. The most striking finding was a gross elevation of IGF-I in diabetic adults with rapidly progressing proliferative disease of the retina. It was postulated that high levels of IGF-I might contribute to or cause the accelerated phase of deterioration and, indeed, the capacity of IGF-I to stimulate cell multiplication is compatible with the hypothesis. Other interpretations are possible, however, and the study has been criticized.[11,12] Nonetheless further research in this area is warranted. Investigators of the study claim that, at the minimum IGF-I levels can serve to identify patients at risk for rapid deterioration of vision and, therefore, may be useful for selecting patients for more vigorous insulin therapy or an alternate form of therapy.

Actions attributed to growth hormone are recognized to be modified by IGF-I and IGF-II.

Children with craniopharyngiomal tumors often exhibit delayed growth and short stature secondary to impaired hypothalamopituitary function. Postoperatively, the impaired growth rate frequently remains low. Recently, 19 children with craniopharyngioma and demonstrated growth hormone deficiency were examined for IGF concentrations as well as for levels of insulin and prolactin.[13] Patients were placed into three groups based on their rate of growth during the first postoperative year. Children in group A showed excessive growth, in group B normal growth and in group C decreased growth. The children in all three groups had low or undetectable growth hormone levels. Measurements of serum IGF levels, however, revealed differences among the three groups which could explain the differences in growth rate. Patients in group C presented with a classic picture of hypopituitarism and exhibited low serum concentrations of IGF-I, prolactin, and insulin. On the other hand, IGF-I levels appeared to be normal and prolactin to be elevated in most patients in groups A and B. Such results are compatible with the notion that IGF-I is a growth mediator. Since all patients exhibited low or absent growth hormone, it was proposed that high prolactin levels shown by patients in groups A and C were responsible for generation of normal amounts of IGF-I. IGF-II levels were normal in most patients in

ree groups implying that generation of IGF-II is less pendent on growth hormone or high circulating olactin than is IGF-I. Insulin levels were low in oups B and C but were elevated in group A. It was ncluded that in group B normal IGF-I levels in sponse to elevated prolactin permitted normal owth whereas the excessive growth in group A pa- nts may have been caused by the action of insulin, esent in excessive concentrations, at IGF-I receptors. ne children in group C with both low insulin and low F-I levels would be predicted, therefore, to fail to grow rmally.

ONCLUSION

Further studies of the role of insulin-like factors and eir receptors in growth regulation undoubtedly will sult in a better understanding of the importance of ese factors in disease. With such advances should me new or better approaches to the pharmacologic ntrol of diabetic retinopathy, growth hormone defi- ncy, or other disorders characterized by abnormal owth.

FERENCES

. Blundell TL, Humbel RE: Hormone families: Pancreatic rmones and homologous growth factors. *Nature* 287: 781, 80.

2. Rechler MM, Nissley SP, King GL, Moses AC, Van Ob- ghen-Schilling E, Romanus JA, Knight AB, Short PA, nite RM: Multiplication stimulating activity (MSA) from the L 3A rat liver cell line: Relation to human somatomedins and insulin. *J Supramol Struct Cell Biochem* 15: 253, 1981.

3. Zapf J, Rinderknecht E, Humbel RE, Froesch ER: Nonsuppressible insulin-like activity (NSILA) from human serum: Recent accomplishments and their physiologic implications. *Metabolism* 27: 1803, 1978.

4. Zapf J, Schoenle E, Froesch ER: Insulin-like growth factors I and II: Some biological actions and receptor binding characteristics of two purified constituents of nonsuppressible insulin-like activity of human serum. *Eur J Biochem* 87: 285, 1978.

5. Kahn CR, Baird KL, Flier JS, Grunfeld C, Harmon JT, Harrison LC, Karlsson FA, Kasuga J, King GL, Lang UC, Podskany JM, Van Obberghen E: Insulin receptors, receptor antibodies, and the mechanism of insulin action. *Rec Prog Hormone Res* 37: 477, 1981.

6. Jacobs S, Cuatrecasas P: Insulin receptors. *Ann Rev Pharmacol Toxicol* 23: 461, 1983.

7. Deutsch PJ, Wan C, Rosen OM, Rubin CS: Latent insulin receptors and possible receptor precursors in 3T3—LI adipocytes. *Proc Natl Acad Sci USA* 80: 133, 1983.

8. Strauss DS: Effects of insulin on cellular growth and proliferation. *Life Sci* 29: 2131, 1981.

9. Larner J, Cheng K, Schwartz C, Kikuchi K, Tamura S, Creacy S, Dubler R, Galasko G, Pullin C, Katz M: Insulin mediators and their control of metabolism through protein phosphorylation. *Rec Prog Hormone Res* 38: 511, 1982.

10. Merriman TJ, Zapf J, Froesch ER: Insulin-like growth factors. Studies in diabetics with and without retinopathy. *N Engl J Med* 309: 527, 1983.

11. Carroll PB: Insulin-like growth factors and diabetic retinopathy. *N Engl J Med* 309: 1649, 1983.

12. Kornbluth A: Insulin-like growth factors and diabetic retinopathy. *N Engl J Med* 309: 1649, 1983.

13. Bucher H, Zapf J, Torresani T, Prader A, Froesch ER, Illig R: Insulin-like growth factors I and II, prolactin, and insulin in 19 growth hormone-deficient children with excessive, normal, or decreased longitudinal growth after operation for craniopharyngioma. *N Engl J Med* 309: 1142, 1983.

Thinking con

Think

As in Blue Cross of New Jersey. *The* single source for computerization.
☐ Because Medical Management Services from Blue Cross now offers a unique automated office system.
☐ Only Blue Cross offers this unique system, because only Blue Cross has the experience in the health care field (half a century's worth!), the data processing know-how and the claims processing expertise to make it all work efficiently and effectively.

The system itself.

You receive a stand-alone system using IBM or Texas Instruments computers that is physically located in your office. It is operated by your office personnel—they do not have to have any data processing experience—and the system is completely under their control at all times.

The software and system support.

This modular system provides a complete software package for your office which utilizes Blue Cross' expertise in health care financing, automated hospital admission/approval systems, automated claims submission, and leadership in paperless processing. Only Blue Cross can offer the benefits of this wealth of experience and offer single source capability for computerization.

Your people receive full and complete training and ongoing support in system operation. We accept full responsibility for hardware and software maintenance.

What the system does for the physician.

Whether you are an individual or group practice, this system will relieve paperwork...provide fast access to necessary patient information...and give you much more time to tend to the clinical aspects of your practice.. and, above all, increase the efficienc of the office and the income of the practice! All from a single source for computerization.

Some of what you get with the System:

- An easy-to-use system.
- Instant access to patient account information by account number.

Take a minute to check this list!

- ☐ Your volume is at least 80 patients per week.
- ☐ Your daily cash control and records keeping procedures need to be improved.
- ☐ Your receivables are greater than 17% of your total annual charges.
- ☐ You are forced to write off more than 5% of your net receivables as uncollectable.
- ☐ You are running behind in your insurance billings and collections.
- ☐ Your service bureau already charges you more than $4,200 per year.
- ☐ You experience a high turnover of clerical employees or need to increase the productivity of your present staff.
- ☐ You find it difficult to get complete and current data on patient treatment patterns, facilities utilization, and services on a regular weekly, monthly and annual basis.
- ☐ Your quarterly and annual payroll reports are now done manually.
- ☐ You have difficulty getting useful management information about your practice when you need it.
- ☐ Your "most current" financial statement for the practice is already out of date.

If you have checked off any of the above, you are a candidate for Medical Management Services.

outerization?

blue.✓

roduction of patients' statements n daily, weekly or monthly basis —whichever billing cycle is best for our practice.

utomatic production of standard nsurance (AMA) claim forms.

daily charge and collection sum- nary which recaps all daily patient ctivity.

n aged accounts receivable trial alance which can be printed on emand.

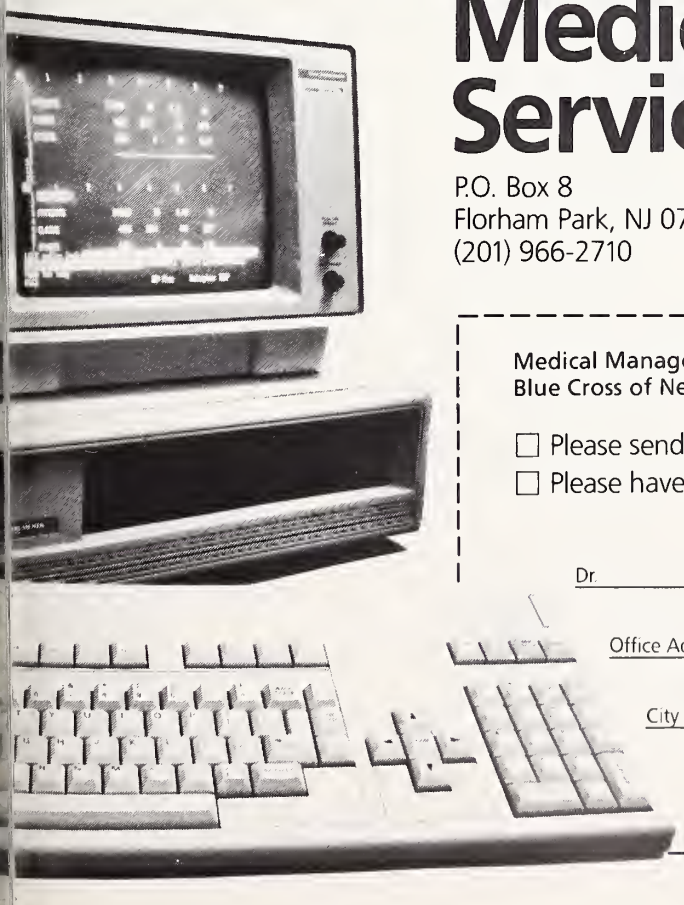
ractice productivity reports broken own by procedures and payment assifications (insurance, self-pay, etc.)

- Monthly management reports.
- Medicare payment distribution (20% of co-pay automatically calculated if assignment is accepted).
- Single-date entry for all financial transactions.
- A recall system which prints lists, statistics and "labels."
- Customized reports for special requirements.
- Automatic retention of claims information for rebilling purposes.
- Improvement in cash flow and office efficiency.

Free Office Analysis

Included in the services provided is a free office analysis where a Medical Management Services representative analyzes pertinent data on your current work flow, patient volume, initial set-up for new patients, billing, insurance filing and follow-up. This Office Analysis is a prerequisite for installation and is made at no charge.

Fill out the coupon, or call, for further details and to initiate your Office Analysis.



Medical Management Services

P.O. Box 8
Florham Park, NJ 07932
(201) 966-2710

Blue Cross of New Jersey ®

Medical Management Services
Blue Cross of New Jersey, P.O. Box 8, Florham Park, NJ 07932

☐ Please send me additional information.
☐ Please have a representative call to arrange an Office Analysis.

Dr. _____

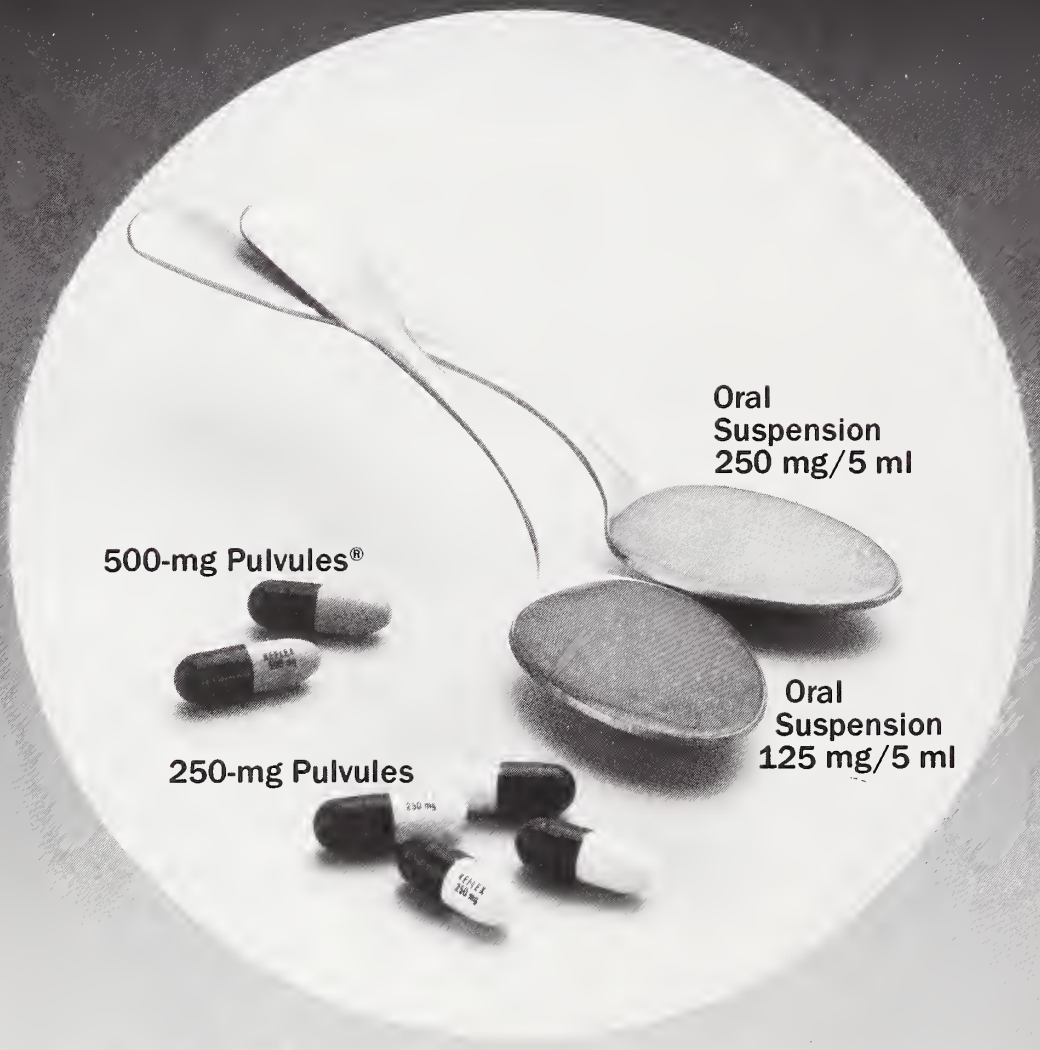
Office Address _____

City _____

State/Zip _____ Office telephone _____

® Registered Marks Blue Cross and Blue Shield Association

Easy To Take



Keflex®
cephalexin

Additional information
available to the profession
on request.

DISTA
420113

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

PEDIATRIC BRIEFS

RICHARD H. RAPKIN, M.D., FRANKLIN C. BEHRLE, M.D., SHYAN C. SUN, M.D., NEWARK*

Pediatric Briefs *are abstracted from the* Newsletter, *a continuing medical education project of the Department of Pediatrics, UMDNJ-New Jersey Medical School and the Children's Hospital of New Jersey.*

eyden JJ: Corn starch, *Candida albicans*, and aper rash. *Pediatr Dermatol* 1:322, 1984.

Growth of *Candida* was not enhanced by corn arch or talcum powder. Both corn starch and talcum duced friction. "The use of these materials as part the overall management of diaper dermatitis ap- ars to be both safe and rational."

Corn starch, for diaper rash, is cheap, universally ailable, and works well. Baby powder containing lcum costs more and smells good. Corn starch is ore absorbent, too. Whether corn starch is indeed tter than talcum has not been studied. Whether ther is needed at all also is not known.

nkey RJ, et al.: Visual hallucinations in children ceiving decongestants. *Br Med J* 288:1369, 1984.

Three children developed visual hallucinations after king usual doses of Actifed®. Other drugs or toxins ere not found. The active ingredient, pseudo- hedrine, was implicated.

Side effects of virtually useless drugs are very im- rtant to note. Since the drug has limited or no ben- t, the cost to benefit ratio depends upon no side fects. If benefits are clear, then occasional mild side fects may be tolerable.

The authors conclude: "Ask about decongestant age when faced with a child presenting with visual llucinations."

ulman ST: The decline of rheumatic fever (RF): hat impact on our management of pharyngitis. *Am Dis Child* 138:426, 1984.

In the 1920s to 1950s, RF was the major cause of death in the age group 5 to 19. There has been a major decline in incidence (we now see one to two cases per year in our hospital compared to one per month or more in 1970) and the decline is unexplained. On the other hand, throat symptoms are now the third most common visit to a physician, throat cultures cost $10 to $12, and some patients with positive throat cultures are not ill with acute streptococcal pharyngitis but rather are long-term carriers.

In a recent symposium cosponsored by Ross Labs and the American Heart Association and endorsed by NIH, the following recommendations were agreed to:

- "Throat cultures should remain the basis for diagnosis..." of strep in the age group 4 to 20; a negative culture avoids unnecessary prescribing of antibiotics.
- Oral penicillin is preferred to benzathine penicillin (except in predictably very poor compliance) because of its reduced anaphylaxis risk. "Whenever practical, therapy should be delayed until culture results are available."

*Abstracts are from the Department of Pediatrics *Newsletter*, UMDNJ-New Jersey Medical Society, Vol. 9, No. 7, 1984. Dr. Rapkin is Editor and Medical Director of Children's Hospital of New Jersey, Newark. Coeditors are Dr. Behrle, Professor and Chairman, Department of Pediatrics, UMDNJ-New Jersey Medical School, and Dr. Sun, Director of Neonatology, Children's Hospital of New Jersey, Newark. Correspondence may be addressed to Dr. Rapkin, Children's Hospital of New Jersey, 15 South 9th Street, Newark, NJ 07107.

• Followup cultures are not indicated since they usually only identify long-term carriers for whom repeated courses of antibiotics are not indicated.

• Cultures of asymptomatic contacts are not indicated.

The American Heart Association will likely adopt these principles very soon. They are eminently reasonable and ought to form the basis for our current management of pharyngitis.

Lo CW, et al.: Chronic protracted diarrhea of infancy: A nutritional disease. *Pediatrics* 72:786, 1983.

Intractable diarrhea of infancy has been known for decades. It is believed to be a vicious cycle of diarrhea, malabsorption, malnutrition, and failure to thrive. Although the mechanisms that contribute may vary, the syndrome which results has mucosal atrophy and malabsorption and the eponym "slick-gut syndrome" has been used. Malnutrition is not only one of the major contributors to intractability (inability to regenerate gut mucosa) but also is the major consequence of the syndrome. After known causes have been ruled out by a thorough workup (and, almost always, this includes a small bowel biopsy), the diagnosis usually is obvious. Treatment often is protracted and requires enteral or parenteral alimentation. Prevention often is possible by recognizing that a nutritional emergency exists in marginally nourished infants with gastroenteritis and acting appropriately: avoidance of iatrogenic starvation, i.e. clear fluids and diluted formulas.

The latter is the most important aspect for the primary care physician to recognize. The small marginally nourished infant with gastroenteritis must be fed. If fluid losses are excessive, the infant can receive parenteral fluid replacement simultaneous with feeding.

Mok JYQ, et al.: Symptoms, atophy, and bronchial reactivity after lower respiratory infection in infancy. Outcome for acute bronchitis, bronchiolitis, and pneumonia in infancy. *Arch Dis Child* 59:299, 306, 1984.

Two hundred children admitted to the hospital with lower respiratory infection were followed for seven years as well as matched controls. Index cases had an increased incidence of cough, wheezing, asthma, and bronchial reactivity compared to controls. When the cases were segregated by disease category (bronchitis, bronchiolitis, pneumonia), there were no differences between but each category differed from controls in the above symptoms and signs. When the cases were segregated by atopic background or not, there were again no difference between, but each category differed from controls, in the same ways.

The authors also noted that bronchial hyper-reactivity was equally distributed among atopic and nonatopic subgroups and speculate that "infection of the respiratory tract during a vulnerable period of lung growth in infancy causes direct injury or induces changes that lead to an increase in respiratory symptoms and impairment of lung function during childhood."

The confusion of which causes what, and what predisposes to which is not clarified by this fine group of studies. The data are worth careful consideratio and add to our storehouses of knowledge, even thou they do not solve the puzzle.

Rumack BH: Acetaminophen overdose in young ch dren. *Am J Dis Child* 138:428, 1984.

This article represents another collaborative stu by the Rocky Mountain Poison Control Center focu ing on the side effects of overdosage by acetaminoph elixirs and alcohol-containing drugs for a specific a group of six years and younger. This research co cluded that when an acetaminophen plus alcohol dr is taken in toxic doses, hepatoprotection occurs, SGPT, SGOT, and bilirubin have a mild increase. T laboratory results are in distinct contrast to to doses of acetaminophen taken alone or with a co bination of other drugs such as propoxyphene, deine, antihistamines, or anticholinergics. The clini level of safety is greater for acetaminophen overdo in a young child compared to an adolescent or adu This indicates some degree of hepatoprotection in t young child to the toxic metabolites of acetaminoph A tenfold increase in dosage is necessary before potential threat exists in the child. However, the p sician still must determine the acetaminophen lev in the blood in any overdosage. If the levels are abo the established nomogram levels at 4 or more hou after ingestion, or by history a patient has inges 150 mg/kg and levels cannot be determined within hours, the specific antidote of oral acetycyste should be started in order to prevent irreversi hepatic damage.

Fever control should be reviewed with parents, p ing specific attention to type of antipyretic and dosage. Because acetaminophen has noncumulat kinetics and levels are not increased in dehydrat states, it is the safest antipyretic for the young ch

Hobbs, CJ: Skull fracture and the diagnosis of abu *Arch Dis Child* 59:246, 1984.

Eighty-nine children under two years of age w skull fracture were studied retrospectively. The fi ture characteristics more often found in abused c dren were: multiple or complex fractures; depress wide and growing fractures; involvement of more th one cranial bone; nonparietal fracture; associated tracranial injury including subdural hematoma. Th were no fractures over 5 mm wide in nonabused c dren and most accidents usually resulted in sin narrow, linear fractures, most commonly of the pari bone. The author suggests that in young child where a minor fall is alleged, the character of a s fracture may help in recognizing abuse.

The author mentions that the diagnosis of ab was assisted by the presence of multiple inju characteristic of abuse in 27 of 29 cases. This is important to recognize and in the author's wo "Many of the children represent the severe end of spectrum of skull fracture in abuse. It is possible 'more gently battered babies' might be indis guishable from those having minor falls." Neverthel the fracture characteristics described in this ar should be useful adjuncts in the ongoing probler diagnosing child abuse.

NJ Members . . .

has never been a better time to improve your Keogh and Corporate Retirement Plans

Care Consulting, Inc. (HCC), primary
e of THE HEALTH CARE GROUP, and
edical Society of New Jersey introduce
ly program for individually designed
nent plans—

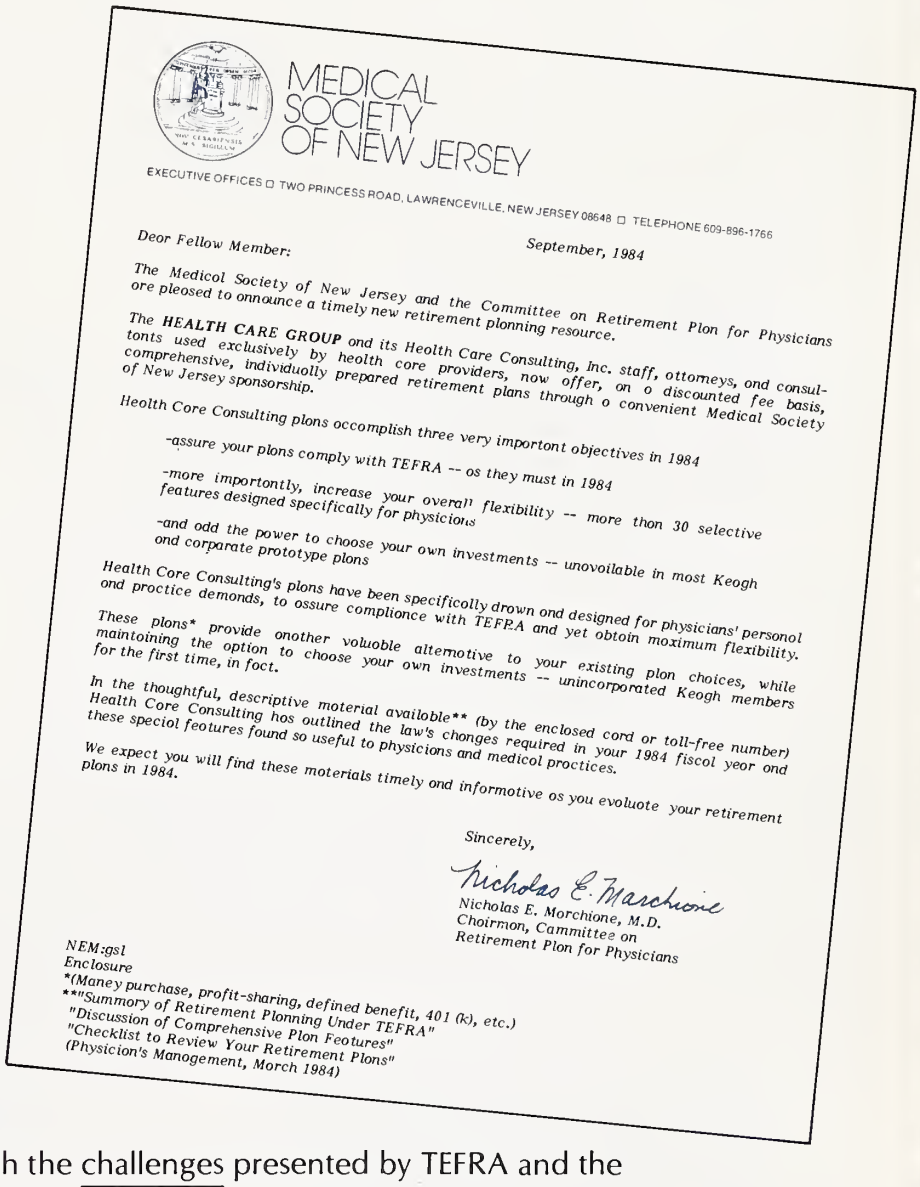
rafted **exclusively** for physicians'
ractice needs

ontaining more than 30 **comprehen-
ve,** frequently overlooked features
valuable to medical practices

mplying with **TEFRA** as you must in 1984

lowing the same **physicians directed
vestment** choices for incorporated and
nincorporated practices

nd providing **innovative Ongoing Plan
ervice**—accessibility to consultation and
dvice, routine amendments and our
xclusive Retirement Planning Newsletter



MEDICAL SOCIETY OF NEW JERSEY

EXECUTIVE OFFICES ☐ TWO PRINCESS ROAD, LAWRENCEVILLE, NEW JERSEY 08648 ☐ TELEPHONE 609-896-1766

Deor Fellow Member: September, 1984

The Medicol Society of New Jersey and the Committee on Retirement Plon for Physicians ore pleosed to onnounce a timely new retirement plonning resource.

The **HEALTH CARE GROUP** ond its Heolth Care Consulting, Inc. staff, ottorneys, ond consultonts used exclusively by heolth core providers, now offer, on o discounted fee basis, comprehensive, individuolly prepared retirement plans through o convenient Medical Society of New Jersey sponsorship.

Heolth Core Consulting plons occomplish three very importont objectives in 1984

-assure your plons comply with TEFRA -- os they must in 1984

-more importontly, increase your overall flexibility -- more thon 30 selective features designed specifically for physicions

-and odd the power to choose your own investments -- unovoilable in most Keogh ond corporate prototype plons

Health Core Consulting's plons have been specificolly drown ond designed for physicians' personol ond proctice demonds, to ossure complionce with TEFRA and yet obtoin moximum flexibility.

These plons* provide onother voluoble olternotive to your existing plon choices, while maintoining the option to choose your own investments -- unincorporated Keogh members for the first time, in foct.

In the thoughtful, descriptive moterial avoilable** (by the enclosed cord or toll-free number) Health Core Consulting hos outlined the law's chonges required in your 1984 fiscol yeor ond these speciol feotures found so useful to physicions and medicol proctices.

We expect you will find these moterials timely ond informotive os you evoluote your retirement plons in 1984.

Sincerely,

Nicholas E. Morchione

Nicholas E. Morchione, M.D.
Choirmon, Committee on
Retirement Plon for Physicians

NEM:gsl
Enclosure
*(Money purchase, profit-sharing, defined benefit, 401 (k), etc.)
**"Summory of Retirement Plonning Under TEFRA"
"Discussion of Comprehensive Plon Feotures"
"Checklist to Review Your Retirement Plons"
(Physicion's Monogement, Morch 1984)

a pivotal year for retirement planning, with the challenges presented by TEFRA and the unity for individually drafted plans.

extremely pleased to work with MSNJ and has prepared informative material on **ment planning under TEFRA,**" "**comprehensive plan features,**" and a "**checklist to review lans,**" available by phoning toll-free or writing —

th Care Group

ociety of New Jersey/
re Consulting, Inc.
HEALTH CARE GROUP
ont Avenue
vyd, PA 19004
-0737
2468

Name _____

Address _____

_____

Phone _____

Unincorporated ☐ Incorporated ☐ Fiscal year ends _____

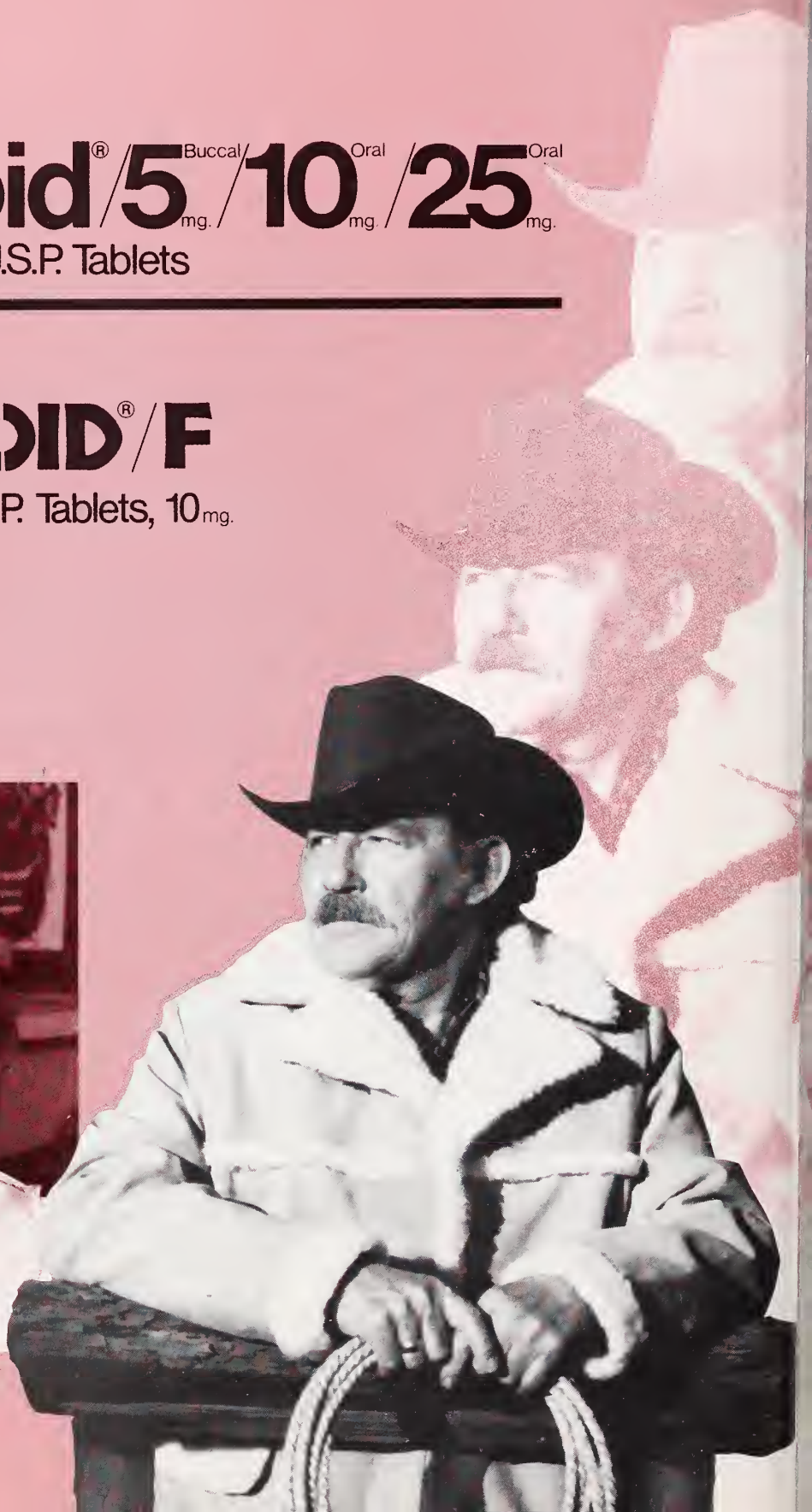
BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android®/5 mg. Buccal/10 mg. Oral/25 mg. Oral
Methyltestosterone U.S.P. Tablets

ANDROID®/F
Fluoxymesterone U.S.P. Tablets, 10 mg.





Trustees' Minutes; UMDNJ Notes; MSNJ Auxiliary; AMNJ Report; Physicians Seeking Location in New Jersey

rustees' Minutes: eptember 16, 1984

A regular meeting of the Board of ustees was held on September 16,)84, at the Executive Offices in awrenceville. Detailed minutes are n file with the secretary of your unty society. A summary of sigficant actions follows:

ew Jersey Orthopaedic Society rant . . . Received a check for ,000, the second of three conibutions from the New Jersey Oropaedic Society.

eport of the President . . .
re Institute of New Jersey . . . oted that MSNJ was honored by e Eye Institute of New Jersey for onsoring the yearly Eye Health reening Program.

eport of the Executive Director . . .
) MSNJ 1984 Membership . . . oted that paid membership was 450 as of August 31, 1984.
) Continuing Medical Education . Noted that a mailing was sent to '0 members who failed to maintain their continuing medical education status.
) Review of MSNJ Financial Statements . . . Reviewed financial statements for the periods ending June 30 and July 31, 1984.
(4) Auto Leasing Proposal . . . Approved the following recommendation:

That staff proceed to negotiate an auto leasing arrangement in accordance with the details outlined in the August 10, 1984, memorandum of the Executive Director.

(5) Status Report on Legal Matters . . .
(a) Subordinated Loan Certificates —Internal Revenue Service . . . Noted that a report of the hearing examiner is expected in November and a decision of the U.S. Tax Court would come shortly thereafter.
(b) State Board of Medical Examiners versus Greco . . . Noted the Appellate Division upheld the SBME decision and MSNJ has filed a petition for certification to the New Jersey Supreme Court.

(6) Regulatory Proposals . . .
(a) State Board of Nursing—Nurse Anesthetists . . . Accepted the following proposal on the basic qualifications for a nurse anesthetist: have a current license to practice as a registered professional nurse; have graduated from a program in nurse anesthesia accredited by the nationally recognized accrediting body approved by the Board of Nursing; have passed the certifying examination administered by that authority; and have maintained the required certification criteria.
(b) State Board of Medical Examiners—Termination of Pregnancy . . . Accepted the following proposal specifying the circumstances under which a medical practitioner could perform certain types of termination of pregnancy at more advanced stages: as long as the procedures are done in licensed health care facilities, and that facilities performing terminations of pregnancy during the second trimester must have a medical director and a credentials committee which evaluates and determines the ability of the operating physician to conduct the various types of termination procedures to be consistent with the health, safety, and welfare of the public.
(c) State Board of Medical Examiners—Delegation of Physical Modalities to Unlicensed Physician Aides . . . Noted MSNJ's generally supportive position on unlicensed physician aides, with the exception of the inclusion of podiatrists and chiropractors directing aides or physical therapists. Noted that the rule was accepted by SBME and MSNJ's letter on the issue was referred to the Credentials Committee.
(7) Medicare Fee Freeze . . . Directed that a fact sheet be developed and circulated to the membership setting forth the pros and cons of the Medicare amendments and an explanation of "participating" and "nonparticipating" physicians. In addition, referred to the Council on Public Relations the motion to take steps to explain this situation to the media with the possibility of a full-page ad in all major New Jersey newspapers. Also, agreed that consideration should be given to providing posters and booklets for distribution in physicians' offices.

Council on Legislation . . .
(1) Assignment of Benefits to Physicians . . . Approved the following recommendation:

That MSNJ seek amendment to the current law, making it a requirement that when assignment of benefits is made by a patient to a physician, the insurance company must pay the physician. Also, if the insurance company inadvertently pays the patient, the insurance company must pay the physician and then retrieve the money from the patient. (It is suggested that the New York State law be used as a guide.)

(2) Current State Legislation . . . Approved all the positions recommended by the Council on Legislation, with the exception of **A-1881, 1882, 1883, 1884,** and **1885** (organ transplants) which were changed from "approved" to "no action." (The list will be published in the next issue.)

(3) Fall Conferences . . . Approved the following recommendation:

That the Fall Conference be devoted to legislative and lobbying activities and be conducted under the auspices of the Council on Legislation.

Committee on Annual Meeting . . .
(1) 1985 Daily Schedule . . . Approved the following recommendation:

That the Board of Trustees approve the proposed daily schedule for the 1985 Annual Meeting.

(2) Sessions of the House of Delegates . . . Approved the following recommendation:

That the Committee on Revision of Constitution and Bylaws be instructed to prepare an amendment to the Bylaws which would transfer the election from the second session of the House of Delegates to the third session of the House of Delegates.

Committee on Retirement Plan for Physicians . . . Noted that the Committee approved the program offered by the Health Care Group and agreed that it should be an endorsed program of MSNJ.

State Board of Medical Examiners . . . Approved the following recommendation:

That should the Medical Inter-Insurance Exchange of New Jersey decide to appeal the case of Ignacio Cruz, M.D., that MSNJ join the case in an amicus position.

Old Business . . .

(1) Health Care Facilities Planning Act—Certificate of Need . . . Agreed to notify the Commissioner of Health that MSNJ will support legislation **(S-1840)** which calls for the total exemption of the private practice of medicine from the certificate of need law.

(2) Special Hearing on UMDNJ's Medical Education Programs . . . Instructed the President or his designee to attend a panel hearing that would be reviewing UMDNJ's medical education programs.

***The Journal* of the Medical Society of New Jersey**

presents

300 YEARS OF MEDICINE IN NEW JERSEY

September 1984

We are celebrating the history of medicine in New Jersey. This special issue illuminates the beginnings of our health care system and the growth of medical care: essays highlight those talented individuals who devoted themselves to this system, and commentaries present the development of specialized care in associated fields of medicine. Plus a special photography section highlighting three statewide exhibits.

Copies of this issue are available by sending $5.00 (check or money order) to MSNJ, Two Princess Road, Lawrenceville, NJ 08648. All MSNJ members will receive one copy of this issue.

Name _____

Address _____

_____

Enclose a $5.00 check or money order for each copy.

Correspondence . . .

(1) From John C. Berry, Director, Department of Health and Human Services, Bureau of Program Operations . . . Noted the response to advertising on behalf of HMOs (Resolution #26):

"Under Section 1876 of the Social Security Act, HMOs can contract with the federal government to enroll Medicare beneficiaries and provide covered services to them. Following an HMO's federal qualification and subsequent contract with the Health Care Financing Administration, and at the request of the HMO itself, notices are mailed out to each beneficiary residing in the service enrollment area of the HMO.

"It is not our intent to promote one health care delivery system over another. The purpose of the notice is simply to inform beneficiaries of the existence of an alternative to the traditional fee-for-service system. Because the federal government has an obligation to notify beneficiaries of federal programs of their rights under these programs, we believe that such mailings are appropriate. The notice was developed to acquaint beneficiaries with an alternative system with which most are unfamiliar.

"The language of the notice, which has been approved by the American Medical Association, was designed to be purely informational in nature not to encourage the use of HMOs over the fee-for-service system. The notice specifically states that enrollment in the HMO is optional and that Medicare beneficiaries who so choose may continue to receive health care from their present physicians and other providers."

(2) From J. Richard Goldstein, M.D., State Commissioner of Health . . . Noted response to Resolution #12 on water pollution:

"Please be assured that we share the concern of the Medical Society of New Jersey as expressed by Resolution #12.

"We have been advised that New York City is in the midst of a construction program to complete the North River and Red Hook treatment plants by the end of 1985. The North River plant is expected to be on line by the time the convention center is

ompleted and it is anticipated that he sewage waste from there will be reated by that plant.

"The issue of the raw sewage discharge by New York City into the Hudson and East Rivers should be addressed in large part by the completion of the two treatment plants. While the elimination of much of the raw sewage discharge should result n some improvement in water quality, there are a number of other factors, such as sludge dumping, industrial discharges, run off, and combined sewer systems which bypass treatment during heavy rains, which negatively impact on water quality in the northern New Jersey-New York area and may affect recreational bathing beaches in Monmouth and Ocean Counties. These issues are being addressed by New Jersey-DEP, the U.S. Environmental Protection Agency, the New York State Department of Environmental Conservation, the New York City Department of Environmental Protection, the Interstate Sanitation Commission, and others.

"I have taken the liberty of forwarding a copy of Resolution #12 to he Interstate Sanitation Commission for their review.

"I would like to commend the Medical Society of New Jersey for taking the time to express your concerns on this issue."

UMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

As this column goes to press, I am awaiting the recommendations of a panel of five distinguished educators and scientists who were named to review our South Jersey medical education programs. In accord with a resolution of the New Jersey Board of Higher Education, the panel was asked to focus on the long-term suitability of the University's multiple existing programs for meeting the State's needs with physicians educated according to the highest standards.

Specific questions being addressed include: Should UMDNJ osteopathic students receive two years of basic science instruction at UMDNJ-Rutgers Medical School in Piscataway and then transfer south for clinical instruction under School of Osteopathic Medicine faculty at SOM's hospital affiliate? Should a basic science capacity be added to SOM so that its entire four-year program is offered in one location?

In late September, the group visited the Piscataway campus, Trenton, and the Camden area to hear firsthand from UMDNJ and Department of Higher Education leaders, as well as other interested parties, on the South Jersey medical education programs.

The panel was to examine the scope, quality, and effectiveness of the medical education which UMDNJ provides in southern New Jersey through UMDNJ-Rutgers Medical School, Camden, and UMDNJ-School of Osteopathic Medicine, Camden and Stratford. New Jersey's need for physicians, the statewide distribution of health care personnel and facilities, and the state's fiscal capability were to be considered.

The consulting group was expected to scrutinize the quality of both existing and proposed curricula, faculty and interschool faculty relationships, educational facilities, student performance, and hospital and professional relationships among both M.D. and D.O. institutions, physicians, and faculty.

We are fortunate to have on the panel for this crucial study Dr. Ivan L. Bennett, Jr., executive vice-president for health affairs of New York University; Dr. Leighton Cluff, executive vice-president of The Robert Wood Johnson Foundation; Dr. Myron Magen, dean of Michigan State University; Dr. Max Michael, Jr., assistant vice-president for health affairs of the University of Florida; and Dr. Steven Beering, M.D., president of Purdue University.

The otolaryngology-head and neck surgery section of UMDNJ-New Jersey Medical School, Newark, has developed a light, flexible silicone rubber prosthesis for the patient whose larynx has been removed and has not succeeded in recovering the ability to speak by using the "burp talk" technique.

With the help of this new prosthetic device, which has been approved by the Food and Drug Administration, most patients easily can learn to speak by diverting air up through the throat and forming word sounds by working the throat muscles. Good results have been obtained in about 40 patients with the device, which costs $25 and lasts three to six months.

Services provided by the "Post-Laryngectomy Voice Rehabilitation Program" at UMDNJ's University Hospital include surgery to prepare the patient for insertion of the prosthesis, instructions in its use, and followup care.

The "New Jersey Larynx," also developed at UMDNJ-New Jersey Medical School, used the patient's skin to form a substitute larynx, but that must be done at the time the larynx is excised surgically.

The purchase of a computerized gamma camera, able to take pictures at the rate of one million counts per second, has been made possible by a $179,000 gift to UMDNJ-Rutgers Medical School by the Fannie E. Rippel Foundation, Madison. The Scinticor will make possible a procedure called "first pass isotope technique" that is safe, painless, and as accurate as possible in evaluating the condition of the patient's heart. The data will enable physicians to prescribe the most effective treatment for their patients and help them to decide which ones would benefit from surgery. A portable unit will be used on cardiac patients at Middlesex General-University Hospital, New Brunswick, before, during, and after heart surgery. It can be used at bedside in intensive care or the operating room. The Scinticor also will be used for research at the medical school.

MSNJ Auxiliary

Grace Gellman
President

The chairman of the Impaired Spouses of Physicians Committee, Josephine Pesaresi, attended the Sixth AMA Conference on the Impaired Physician in Secaucus. Also, representing the Auxiliary was Bergen County Medical Society Auxiliary President, Barbara Goldstein.

The Fall Leadership Workshop in Lawrenceville was well attended and enthusiastically received. John J. Moore, Ph.D., Professor at Loyola University, Chicago, presented a dynamic program on "Avenues Leading to Personal Success," and "Ingredients for Self-Assurance."

Five county presidents-elect—representing Bergen, Mercer, Salem, Sussex, and Union Counties—

attended the AMA Auxiliary Leadership Confluence in October in Chicago.

Evelyn Basralian, convention chairman, and the Committee, met at Americana Host Farm Resort in Lancaster. The members really have a treat in store during May 2-5, 1985. A fun program, together with the regular business, is in the planning stage.

It is time to think "holidays." AMA-ERF chairman, Marilyn Pashuck, has great boutique items and at a saving. Invite her to your county meetings and just see. Consult your county auxiliary AMA-ERF chairman to assist you in selecting holiday cards for your office from an outstanding selection.

Happy Thanksgiving!

AMNJ Report

Robert S. Rigolosi, M.D.
President

In late August, the Academy of Medicine mailed its popular *Annual Calendar for 1984-1985* to all Fellows and Institutional Members throughout New Jersey. Receipt of this publication always is a signal that the academic year is about to begin and it appears from the impressive content that this will be our most prolific year ever.

On September 12, our Education Committee, under the chairmanship of Dr. Al Alessi, held their annual joint meeting with our scientific section officers. The purpose of the meeting was to orient the new committee members and section officers to their role in the category I accreditation process and the mechanism to schedule section meetings. Over 30 members and staff were in attendance.

The Academy in conjunction with the Medical Society of New Jersey and the AHME of New Jersey held a workshop on CME essentials on Wednesday, September 18, 1984, at the Executive Offices. The Workshop, designed for directors of medical education, coordinators of CME, hospital medical directors, quality assurance directors, and hospital staff involved in CME management, studied the following: exposure to a broad range of needs assessment procedures from faculty and fellow participants; needs assessment concepts and techniques which best apply to a particular environment; one or more accreditation site survey scenarios and determination of the collegial and consultative nature of the site survey process; and definition of what is expected in the accreditation and site survey process.

On Saturday, October 13, 1984, the Academy will be sponsoring its first major symposium of the academic year. The program, "Hyperthermia for Cancer," will be held at the Executive Offices and the program chairman is Dr. Arthur Winter. The symposium will present the most current scientific information concerning the concomitant use of hyperthermia in the treatment of cancer of the body, including the brain.

Our second major symposium will be held on Saturday, October 20, 1984, at the Town and Campus Restaurant in West Orange. Dr. Donald Louria will chair, "Potential Human and Ecologic Disasters," which among other areas will examine the health effects of exposure to leakage from chemical toxic waste disposal sites and all the available studies that have been completed will be reviewed and the requirements for additional study will be analyzed. High and low level radiation exposure consequences also will be discussed.

The speaker for the Academy's first First Wednesday program of the year was Dr. David Rogers, president of the Robert Wood Johnson Foundation. Dr. Rogers addressed the topic, "Cutting Medical Care Costs," with comments from his recent *JAMA* article.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY—Howard Ang, M.D., 7-29 Hegeman Ave., #3-A, Brooklyn, NY 11212. Far Eastern University 1976. Group or partnership. Available January 1985.

FAMILY MEDICINE—Mary F. Campagnolo, M.D., 10 Overlook Rd., Apt. 5-E, Summit, NJ 07901. George Washington University 1982. Board eligible. Group or partnership. Available July 1985.

Cary A. Davidson, M.D., 100B Finderne Ave., Bridgewater, NJ 08807. SUNY-Upstate 1982. Board eligible. Rural or suburban practice, family practice, solo, group. Available July 1985.

GASTROENTEROLOGY—Kenneth Russell Feuer, M.D., 3120 Parkway, Cheverly, MD 20785. Baylor 1980. Also, internal medicine. Board certified (IM). Available July 1985.

Henry J. Katz, M.D., 20 Waterside Plaza, New York, NY 10010. Albany Medical College 1980. Board certified (IM). Group or partnership. Available.

Eliot H. Zimbalist, M.D., 430 East 67 St., Apt. 12F. New York, NY 10021. Mt. Sinai 1980. Also internal medicine. Board certified (IM). Group, partnership, multispecialty. Available July 1985.

GENERAL MEDICINE—Parviz Babalavi, M.D., 6265 Austin St., Rego Park, NY 11374. Tehran (Iran). Hospital or office setting, ENT background. Available.

INTERNAL MEDICINE—David M. Breidbart, M.D., 50 Hillpark Ave., Apt. 1-R, Great Neck, NY 11021. SUNY-Downstate 1979. Also pulmonary medicine. Board certified (IM); board eligible (PM). Pulmonary, pulmonary/internal medicine, multispecialty group. Available July 1985.

Kenneth Russell Feuer, M.D., 3120 Parkway, Cheverly, MD 20785. Baylor 1980. Also, gastroenterology. Board certified. Available July 1985.

Cory Krueger, M.D., 2301 Woodward St. Apt. C-12, Philadelphia, PA 19115. Rutgers 1982. Board eligible. Group or partnership. Available July 1985.

Gianfranco Umberto Meduri, M.D., 430 East 67 St., Apt. 9C, New York, NY 10021. Padua (Italy) 1977. Also, pulmonary. Board certified (IM). Group, academic, industrial. Available August 1985.

Virod K. Shah, M.D., 345 Watkins Lane, Battle Creek, MI 49017. M.P. Shah (India) 1975. Board eligible. Any type practice. Available.

Robert L. Werner, D.O., 148 Reservoir Rd., Parsippany, NJ 07054. UMDNJ-NJSOM 1981. Board eligible. Solo or partnership. Available July 1985.

OBSTETRICS/GYNECOLOGY—Nissim Contente, M.D., 7300 Cedar Post Rd., Apt. 10E, Liverpool, NY. Guadalajara (Mexico) 1979. Board eligible. Group or partnership. Available July 1985.

Amnon Fein, M.D., 223 East Ave., Apt. 6B, Syracuse, NY 13224. Guadalajara (Mexico) 1980. Group or partnership. Available July 1985.

OCCUPATIONAL MEDICINE—Errol Emmet Vernon, M.D., 2018 Pickerton Dr., Deer Park, TX 77536. University of the West Indies (Jamaica) 1978. Board eligible. Group. Available.

PTHALMOLOGY—George R. Coar, M.D., 3245 Beechwood Blvd., Apt. C-11, Pittsburgh, PA. Jefferson 1981. Board eligible. Group, partnership, solo. Available July 1985.

Peter J. Famiglietti, M.D., Box 76, R.D. #5, Danville, PA 17821. University of Connecticut 1981. Board eligible. Group or partnership. Available July 1985.

Barry N. Shaklan, M.D., 6207 Blackberry Lane, Dallas, TX 75248. Seton Hall 1961. Board certified. Available.

ATHOLOGY—Steven P. Katz, M.D., 9634 S. Karlov Ave., Oak Lawn, IL 60453. Nebraska 1972. Board certified (PA and CLIN). Hospital or group. Available on one month's notice.

EDIATRICS—Charles H. Geneslaw, M.D., 8372 Loveridge Ct., Richmond, VA 23229. UMDNJ 1982. Partnership. Available July 1985.

Nellie Novak, M.D., 1015 West Cherry Hill Apts. Cherry Hill, NJ 08002. Sverdlovsk (USSR) 1974. Board eligible. Group, partnership, HMO. Available July 1985.

ULMONARY MEDICINE—David M. Breidbart, M.D., 50 Hillpark Ave., Apt. 1-R, Great Neck, NY 11021. SUNY-Downstate. Also, internal medicine. Board eligible (PM); board certified (IM). Pulmonary, pulmonary/internal medicine, multispecialty group. Available July 1985.

Gianfranco Umberto Meduri, M.D., 430 East 67 St., Apt. 9C, New York, NY 10021. Padua (Italy) 1977. Also, internal medicine. Board certified (IM). Group, academic, industrial. Available August 1985.

URGERY—Victor P. Bruno, M.D., 702 Fordham Rd., Bala Cynwyd, PA 19004. Georgetown 1978. Board eligible. Group or partnership. Available May 1986.

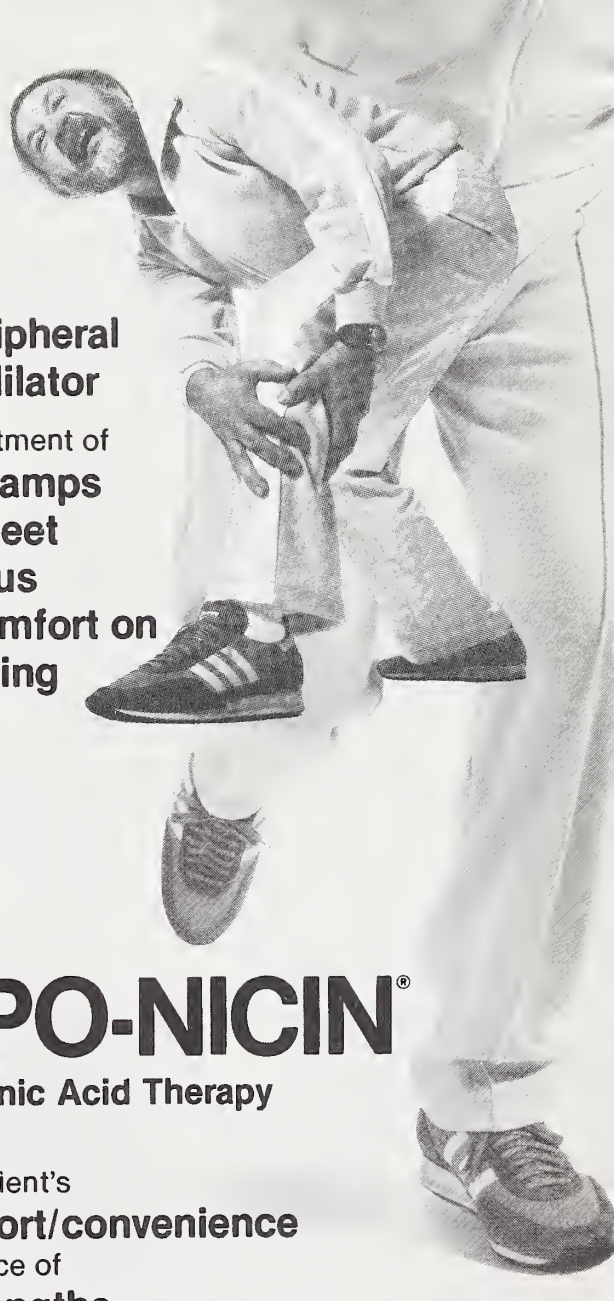
Daniel M. Goldman, M.D., 3450 Wayne Ave., Apt. 19-S, Bronx, NY 10467. Also, vascular surgery. Board eligible. Partnership or single specialty group. Available July 1985.

David A. Guthrie, M.D., 3130 Heathstead Pl., Charlotte, NC 28210. West Virginia 1978. Also, vascular surgery. Board eligible. Group or partnership. Available July 1985.

SURGERY, VASCULAR—Daniel M. Goldman, M.D., 3450 Wayne Ave., Apt. 19-S, Bronx, NY 10467. Also, general surgery. Board eligible. Partnership or single specialty group. Available July 1985.

David A. Guthrie, M.D., 3130 Heathstead Pl., Charlotte, NC 28210. West Virginia 1978. Also, general surgery. Board eligible. Group or partnership. Available July 1985.

UROLOGY—Richard S.D. Tushman, M.D., 519 Vantage Pl., Richmond, VA 23236. Cornell 1980. Board eligible. Available July 1985.



A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release
LIPO-NICIN®/300 mg.

Each time-release capsule contains:
Nicotinic Acid .....300 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release
LIPO-NICIN®/250 mg.

Each yellow tablet contains:
Nicotinic Acid .....250 mg.
Niacinamide .....75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide .....75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

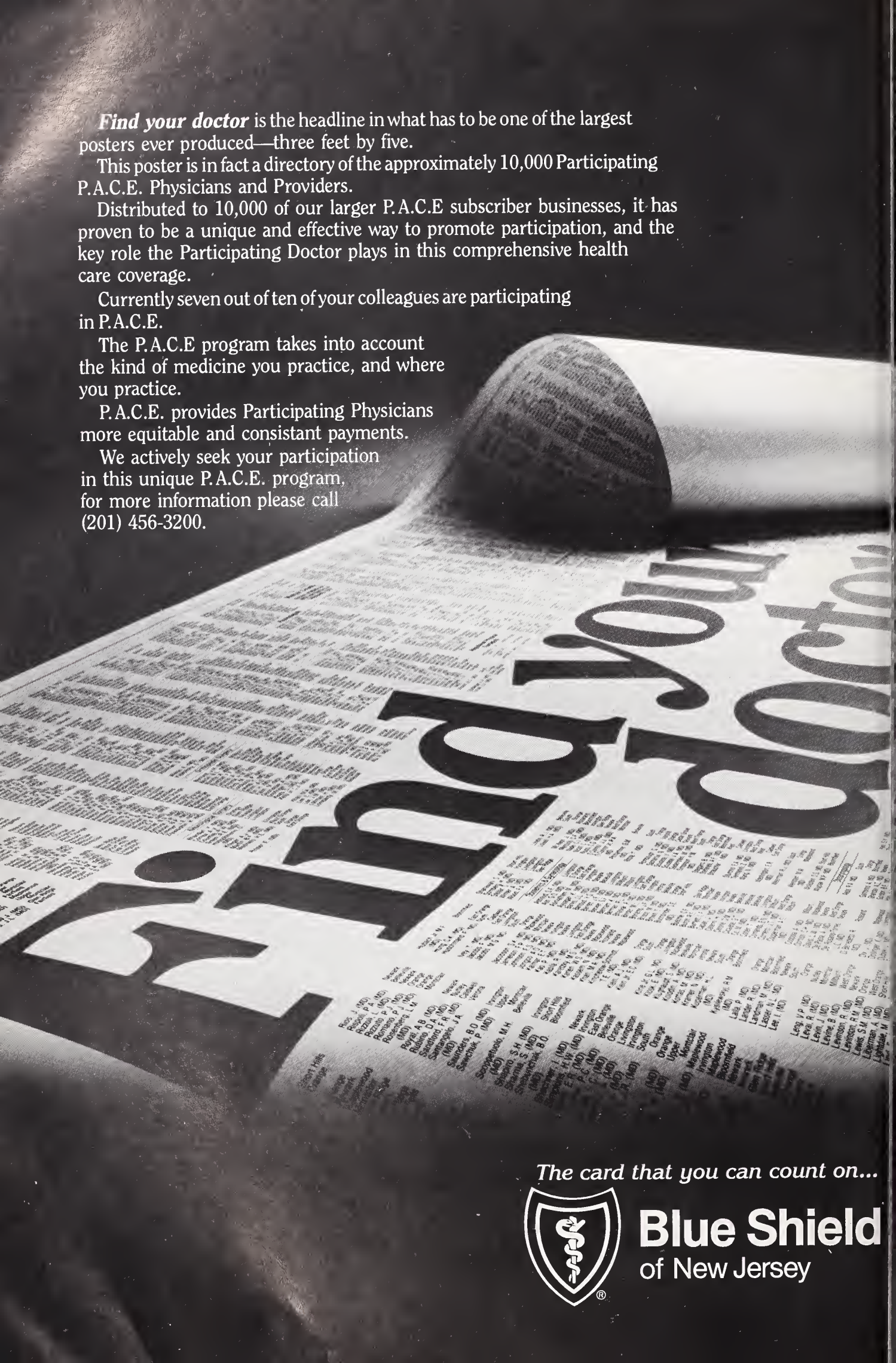
Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR


Find your doctor
Find your doctor is the headline in what has to be one of the largest posters ever produced—three feet by five.
This poster is in fact a directory of the approximately 10,000 Participating P.A.C.E. Physicians and Providers.
Distributed to 10,000 of our larger P.A.C.E subscriber businesses, it has proven to be a unique and effective way to promote participation, and the key role the Participating Doctor plays in this comprehensive health care coverage.
Currently seven out of ten of your colleagues are participating in P.A.C.E.
The P.A.C.E program takes into account the kind of medicine you practice, and where you practice.
P.A.C.E. provides Participating Physicians more equitable and consistant payments.
We actively seek your participation in this unique P.A.C.E. program, for more information please call (201) 456-3200.
The card that you can count on...
Blue Shield
of New Jersey

984-1985 COMMITTEES & COUNCILS

ANDING COMMITTEES

mmittee on Annual Meeting
aff Liaison, Eileen Pfeiffer)

nk R. Romano, Sr., M.D.,
Chairman (1985) ..... Dunellen
mas J. Connolly, Jr., M.D. (1987) ..... Jersey City
rren E. Crane, M.D. (1986) ..... Trenton
want G. Keswani, M.D. (1987) ..... Livingston
n F. Marshall, M.D. (1986) ..... Trenton
l A. Restivo, Sr., M.D. (1985) ..... Wayne
. John Holdcraft, *Auxiliary*
Member (1985) ..... Woodbury
hur Bernstein, M.D., *Secretary,*
Ex-officio Member ..... South Orange
l S. Cherashore, M.D., *Consultant* ..... Nutley
rving Dunn, M.D., *Consultant* ..... Mantoloking
drew G. Hudacek, M.D., *Consultant* ..... Morristown
arles S. Krueger, M.D., *Consultant* ..... Mount Holly
eph E. Salvatore, M.D., *Consultant* ..... Tenafly

entific Program (Sections)
aff Liaison, Eileen Pfeiffer)

ergy
gela S. Salanito, M.D., *Chairman* ..... Upper Montclair
d Bigelsen, M.D., *Secretary* ..... Dover

esthesiology
ger A. Moore, M.D., *Chairman* ..... Moorestown
ia Hupert, M.D., *Secretary* ..... Livingston

diovascular Diseases
dul N. Timmapuri, M.D., *Chairman* ..... Ridgefield Park
ay K. Thamman, M.D., *Secretary* ..... Lodi

est Diseases
in Berlin, M.D., *Chairman* ..... Jersey City

nical Pathology
ng H. Hyun, M.D., *Chairman* ..... Plainfield
bert R. Rickert, M.D., *Secretary* ..... Livingston

rmatology
H. Gouterman, M.D., *Chairman* ..... Roseland

ergency Medicine
ert H. Helm, M.D., *Chairman* ..... West Collingswood
dolf E. Schwaeble, M.D., *Secretary* ..... Mendham

nily Practice
ristopher Babigian, M.D.,
Chairman ..... Paramus

stroenterology, Colon and Rectal Surgery
H. Fischer, M.D., *Chairman* ..... Fair Lawn
n C. McConnell, M.D., *Secretary* ..... Fair Lawn

urosurgery and Neurology
an L. Gardner, M.D., *Chairman* ..... Summit
urice M. Davidson, M.D., *Secretary* ..... Somers Point

stetrics and Gynecology
seph A. Varallo, M.D., *Chairman* ..... Atlantic City
rnard A. Pekala, M.D., *Secretary* ..... Cherry Hill

cology
xander Z. Haas, M.D., *Chairman* ..... New Brunswick
lliam M. Schulman, M.D., *Secretary* ..... Lakewood

hthalmology
ul M. Tishler, M.D., *Chairman* ..... Willingboro
vid I. Gerstein, M.D., *Secretary* ..... Irvington

hopaedic Surgery
njamin I. Smolenski, M.D., *Chairman* ..... Mt. Laurel
bert J. Weierman, M.D., *Secretary* ..... South Orange

olaryngology, Head and Neck Surgery
gmund L. Sattenspiel, M.D., *Chairman* ..... Freehold
phen F. Mattel, M.D., *Secretary* ..... Clifton

diatrics
ward Arkans, M.D., *Chairman* ..... Moorestown

ysical Medicine and Rehabilitation
ampa V. Bid, M.D., *Chairman* ..... West Orange
n J. Kraus, M.D., *Secretary* ..... Morristown

astic and Reconstructive Surgery
gene C. Carroccia, M.D., *Chairman* ..... Ventnor City

ychiatry
nneth J. Rubin, M.D., *Chairman* ..... Long Branch

Radiology
Charles A. Whelan, M.D., *Chairman* ..... Montclair
David V. Habif, Jr., M.D., *Secretary* ..... Teaneck

Rheumatology
Kenneth H. Maurer, M.D., *Chairman* ..... Cherry Hill
David M. Sagransky, M.D., *Secretary* ..... Linwood

Surgery
Edward W. Verner, M.D., *Chairman* ..... Newark
Ralph S. Greco, M.D., *Secretary* ..... New Brunswick

Advisory Committee to the Auxiliary
(Staff Liaison, Shirley Walsh)

Frank R. Romano, Sr., M.D., *Chairman* (1985) . Dunellen
George T. Hare, M.D.,
Vice-Chairman (1986) ..... Haddonfield
Ralph J. Fioretti, M.D.,
President-Elect (1986) ..... Rochelle Park
Werner J. Hollendonner, M.D. (1985) ..... Hamilton Square
Joseph N. Micale, M.D. (1987) ..... North Bergen
J. James Pegues, M.D. (1987) ..... Mount Holly
Mrs. Ralph B. Wayman, Jr., *Auxiliary*
Member (1985) ..... Yardley, PA

Committee on Credentials
(Staff Liaison, Arthur White)

Arthur Bernstein, *Chairman, Secretary,*
Ex-officio Member ..... South Orange
Thomas E. Mattingly, Jr., M.D.,
Vice-Chairman (1985) ..... Mount Holly
William A. Allgair, M.D. (1985) ..... South River
Edward M. Coe, M.D. (1986) ..... Cranford
James N. Judson, M.D. (1987) ..... Cape May Court House
Roger C. Laauwe, M.D. (1986) ..... Wayne
Lawrence B. Owen, M.D. (1987) ..... Salem

Committee on Finance and Budget
(Staff Liaison, Arthur White)

Harry M. Carnes, M.D., *Chairman* (1987) ..... Audubon
Palma E. Formica, M.D.,
Vice-Chairman (1985) ..... Old Bridge
Douglas M. Costabile, M.D. (1987) ..... Murray Hill
Matis A. Fermaglich, M.D. (1987) ..... Teaneck
Edward A. Schauer, M.D. *First*
Vice-President (1987) ..... Farmingdale
B. Ralph Wayman, Jr., M.D. (1986) ..... Yardley, PA
Mrs. Elmer Grimes, *Auxiliary*
Member (1985) ..... Haddonfield
Paul J. Hirsch, M.D., *Treasurer, Ex-officio*
Member ..... Bridgewater

Committee on Medicaid
(Staff Liaison, Joseph C. Lucci)

Thomas S. Bellavia, M.D.,
Chairman ..... Hasbrouck Heights
James Q. Atkinson, M.D. ..... Vincentown
Gertrude B. Brundage, M.D. ..... East Orange
Bayard Coggeshall, M.D. ..... Morristown
Jonathan C. Gibbs, M.D. ..... Jersey City
Sheldon Lang, M.D. ..... Passaic
Arganey L'Avnire Lucas, Jr., M.D. ..... Morristown
Bernard A. Pekala, M.D. ..... Cherry Hill
Carl J. Records, M.D. ..... Rio Grande
William Silverman, M.D. ..... Atlantic City
Murray Pine, D.O., *Consultant* ..... Newark
Frank Y. Watson, M.D., *President,*
Invited Guest ..... Glen Ridge
Ralph J. Fioretti, M.D., *President-Elect,*
Invited Guest ..... Rochelle Park
I. Fulton Erlichman, M.D., *Invited Guest* ..... Trenton
Jack Kallop, *Invited Guest* ..... Millville
Thomas Russo, *Invited Guest* ..... Trenton
S. Eugene Yuliano, M.D., *Invited Guest* ..... Trenton
Joseph C. Lucci, *Invited Guest* ..... Lawrenceville

Vincent A. Maressa, *Executive Director, Invited Guest* ..... Lawrenceville

Committee on Medical Defense and Insurance
(Staff Liaison, Joseph C. Lucci)

Michael J. Doyle, M.D., *Chairman* (1985) ..... Neptune
E. Arthur Kratzman, M.D., *Vice-Chairman* (1987) ..... Plainfield
Albert M. Doswald, M.D. (1987) ..... Bridgewater
Stanley Karp, M.D. (1985) ..... Cinnaminson
Carl A. Restivo, Jr., M.D. (1986) ..... Jersey City
Harvey P. Yeager, M.D. (1986) ..... West Orange
Mrs. William Allgair, *Auxiliary Member* (1985) ..... South River
Suresh G. Wabel, M.D., *Resident Member* (1985) ..... Edison
Christopher Seidler, *Student Representative* ..... New York, NY
Arthur Bernstein, M.D., *Secretary, Ex-officio Member* ..... South Orange
William H. Ainslie, Sr., M.D., *Consultant* ..... Metuchen
Joseph V. Bocchino, M.D., *Consultant* ..... Westfield
Anthony J. Bruno, M.D., *Consultant* ..... Elizabeth
William J. D'Elia, M.D., *Consultant* ..... Spring Lake
John D. Franzoni, M.D., *Consultant* ..... Trenton
Ernest C. Hillman, Jr., M.D., *Consultant* ..... Glen Ridge
Paul J. Kreutz, M.D., *Consultant* ..... Elizabeth
Henry Liss, M.D., *Consultant* ..... Chatham
Jesse Schulman, M.D., *Consultant* ..... Lakewood

Committee on Medical Education
(Staff Liaison, Martin E. Johnson)

Edwin W. Messey, M.D., *Chairman* (1987) ..... Willingboro
Stephen Colameco, M.D. (1985) ..... Camden
Brewster S. Miller, M.D. (1986) ..... Somerville
Roberta G. Rubin, M.D. (1986) ..... Glen Ridge
Sanford H. Vernick, M.D. (1985) ..... Hazlet
Stephen F. Wang, M.D. (1987) ..... Morristown
Mrs. Joseph Basralian, *Auxiliary Member* (1985) ..... Hasbrouck Heights
Jerome Yatskowitz, *Student Representative* (1985) ..... Maplewood
Alfred A. Alessi, M.D., *Consultant* ..... Hackensack
Arthur Bernstein, M.D., *Secretary, Consultant* ..... South Orange
William C. Black, M.D., *Consultant* ..... Hackensack
Alfonse A. Cinotti, M.D., *Consultant* ..... Jersey City
Samuel F. D'Ambola, M.D., *Consultant* ..... Atlantic Highlands
Burton M. Feinsmith, M.D., *Consultant* ..... Westfield
Paul J. Hirsch, M.D., *Treasurer, Consultant* . Bridgewater
Anthony B. Minnefor, M.D., *Consultant* ..... Paterson
William F. Minogue, M.D., *Consultant* ..... Summit
Dryden Morse, M.D., *Consultant* ..... Browns Mills
Robert S. Rigolosi, M.D., *Consultant* ..... Paramus
William S. Vaun, M.D., *Consultant* ..... Long Branch

Committee on Medical Student Loan Fund
(Staff Liaison, Arthur White)

David Greifinger, M.D., *Chairman* (1985) ..... Belleville
Antonio P. Battaglia, M.D. (1985) ..... Gibbstown
Palma E. Formica, M.D. (1986) ..... Old Bridge
Theodora J. Maio, M.D. (1987) ..... Clifton
James P. Thompson, M.D. (1986) ..... Upper Montclair
Mrs. Ralph B. Wayman, Jr., *Auxiliary Member* (1985) ..... Yardley, PA

Committee on Publication
(Staff Liaison, Geraldine Hutner)

Paul J. Hirsch, M.D., *Treasurer, Chairman* (1985) ..... Bridgewater
Dirck L. Brendlinger, M.D. (1987) ..... Marlton
Frederick B. Cohen, M.D. (1986) ..... Newark
A. Olusegun Fayemi, M.D. (1987) ..... Teaneck
Robert M. MacMillan, M.D. (1985) ..... Browns Mills
Leon G. Smith, M.D. (1986) ..... Roseland
Mrs. Ralph J. Fioretti, *Auxiliary Member* (1985) ..... Rochelle Pa
Ralph J. Fioretti, M.D., *President-Elect, Ex-officio Member* ..... Rochelle Pa
Arthur Bernstein, M.D., *Secretary, Ex-officio Member* ..... South Oran
Arthur Krosnick, M.D., *Editor, Ex-officio Member* ..... Trent

Committee on Revision of Constitution and Byla
(Staff Liaison, Diana C. Gore)

John H. Lifland, M.D., *Chairman* (1986) ..... Somerv
William Greifinger, M.D., *Vice-Chairman* (1985) ..... Bellev
William A. Allgair, M.D. (1987) ..... South Ri
Michael M. Heeg, M.D. (1985) ..... Trent
Pascal A. Pironti, M.D. (1987) ..... Sumi
Ford C. Spangler, M.D. (1986) ..... Sal
Mrs. James Brennan, *Auxiliary Member* (1985) ..... Cherry
Arthur Bernstein, M.D., *Secretary, Ex-officio Member* ..... South Ora
Hillel M. Ben-Asher, M.D., *Consultant* ..... Morristo
William J. D'Elia, M.D., *Consultant* ..... Spring L
John S. Madara, M.D., *Consultant* ..... Sal
Henry J. Mineur, M.D., *Consultant* ..... Westfi
Charles I. Nadel, M.D., *Consultant* ..... Irving
Carl A. Restivo, Jr., M.D., *Consultant* ..... Jersey
Bernard Robins, M.D., *Consultant* ..... Springfi

ADMINISTRATIVE COUNCILS

Council on Legislation
(Staff Liaison, June O'Hare)

Irving P. Ratner, M.D., *Chairman* (1986) ..... Willingb
Howard H. Lehr, M.D., *Vice-Chairman* (1987) ... Fanw
L. Willis Allen, M.D. (1987) ..... Milh
Anthony P. Caggiano, Jr., M.D. (1986) ..... Glen Ri
Thomas J. Connolly, Jr., (1985) ..... Jersey
William J. D'Elia, M.D. (1986) ..... Spring L
Leon A. Fraser, M.D. (1985) ..... Tren
S. Stuart Mally, M.D. (1985) ..... Atlantic
Joseph N. Micale, M.D. (1986) ..... North Ber
Bernard A. Rineberg, M.D. (1987) ..... New Brunsv
Arne L. Skilbred, M.D. (1987) ..... Glen R
Irving Weiss, M.D. (1985) ..... Pompton Pla
Mrs. Frank Campo, *Auxiliary Member* (1985) ..... Tren
William D. Salerno, M.D., *Resident Member* (1985) ..... Saddle Br
David M. MacPeek, M.D., *Alternate Resident Member* (1985) ..... Bensalem
Thomas M. Fynan, *Student Representative* (1985) ..... Some
Joseph P. Cillo, M.D., *Consultant* ..... Cran
Frank Gingerelli, M.D., *Consultant* ..... Hackens
R. Gregory Sachs, M.D., *Consultant* ..... Sum

Council on Medical Services
(Staff Liaison, Joseph C. Lucci)

Joseph W. Fleisher, M.D., *Chairman* (1985) ..... Scotch Pl
Richard H. Sharrett, M.D., *Vice-Chairman* (1986) ..... Plain
Joel S. Cherashore, M.D. (1985) ..... Nu
Stuart Hirsch, M.D. (1986) ..... Bridgew
John S. Madara, M.D. (1986) ..... Sa
John J. Pastore, M.D. (1987) ..... Vine
Lindsay L. Pratt, M.D. (1986) ..... Cam
Robert S. Rigolosi, M.D. (1985) ..... Para
Herman M. Robinson, M.D. (1987) ..... Living
David A. Willard, M.D. (1985) ..... Princ
Edwin S. Wilson, M.D. (1987) ..... Mount H
Frank A. Wolf, M.D. (1987) ..... Phillipsb
Mrs. Frank R. Romano, Sr., *Auxiliary Member* (1985) ..... Plain
Ralph J. Fioretti, M.D., *President-Elect, Ex-officio Member* ..... Rochelle

Matthew J. Speesler, M.D., *Resident Member* (1985) ..... Somerset
Melinda S. Lantz, *Student Representative* (1985) ..... Piscataway
Victor H. Boogdanian, M.D., *Consultant* . New Brunswick
Carl T. Franzoni, M.D., *Consultant* ..... Trenton
Carl A. Restivo, Jr., M.D., *Consultant* ..... Jersey City
Jeffrey M. Solomon, M.D., *Consultant* ..... Vineland
Robert H. Stackpole, M.D., *Consultant* ..... Roselle

Council on Mental Health
(Staff Liaison, Joseph C. Lucci)

George L. Triebenbacher, M.D., *Chairman* (1985) ..... Beach Haven
William H. Bristow, Jr., M.D., *Vice-Chairman* (1986) ..... Ridgewood
Churchill L. Blakey, M.D. (1987) ..... Wenonah
Carrell R. Crouse, M.D. (1985) ..... Woodstown
Alvin Friedland, M.D. (1986) ..... Livingston
Morton Friedman, M.D. (1985) ..... Millburn
J.J. George, M.D. (1985) ..... Vineland
Thomas R. Houseknecht, M.D. (1986) ..... Moorestown
Joseph J. Kline, M.D. (1987) ..... Trenton
William R. Nadel, M.D. (1987) ..... Plainfield
Thomas Robbins, M.D. (1987) ..... Hightstown
Gerald H. Rozan, M.D. (1986) ..... Wayne
Mrs. Alexander D. Kovacs, *Auxiliary Member* (1985) ..... Scotch Plains
David Nover, *Student Representative* (1985) ..... Somerset
Alexander D. Kovacs, M.D., *Immediate Past-President, Ex-officio Member* ..... Scotch Plains
Harry H. Brunt, Jr., M.D., *Consultant* ..... Wall
Arnold M. Kallen, M.D., *Consultant* ..... Piscataway
Martin H. Weinberg, M.D., *Consultant* ..... West Trenton

Council on Public Health
(Staff Liaison, Joseph C. Lucci)

Charles J. Moloney, M.D., *Chairman* (1987) ..... Moorestown
Richard C. Reynolds, M.D., *Vice-Chairman* (1986) ..... Piscataway
David J. Blackman, M.D. (1986) ..... Wayne
Edward M. Coe, M.D. (1986) ..... Cranford
Thomas E. Desmond, M.D. (1985) ..... Edison
Albert Ehrlich, M.D. (1985) ..... Fort Lee
Henry A. Katz, M.D. (1985) ..... Mountain Lakes
Glenn P. Lambert, M.D. (1987) ..... Flemington
William Pawluk, M.D. (1986) ..... Medford
Narasimhaloo Venugopal, M.D. (1987) ..... Vineland
Joseph P. Zawadsky, M.D. (1985) ..... New Brunswick
Mrs. Guillermo Garcia, *Auxiliary Member* (1985) ..... Bayonne
Paul Feldan, (1985) *Student Representative* ..... New Brunswick
Faith E. Nathan, *Alternate Student Representative* ..... Moorestown
Edward A. Schauer, M.D., *First Vice-President, Ex-officio Member* ..... Farmingdale
Ronald Altman, M.D., *Consultant* ..... Trenton

Council On Public Relations
(Staff Liaison, Martin E. Johnson)

Louis G. Bosco, M.D., *Chairman* (1987) ..... Clifton
Joseph W. Bitsack, M.D., *Vice-Chairman* (1987) ..... Hackensack
John E. Durst, M.D. (1986) ..... Freehold
Armando F. Goracci, M.D. (1985) ..... Woodbury
Michael M. Heeg, M.D. (1986) ..... Trenton
Robert J. Lorello, M.D. (1986) ..... Belleville
Jon Marsicano, M.D. (1985) ..... Iselin
Edwin W. Messey, M.D. (1985) ..... Willingboro
John J. Pastore, M.D. (1987) ..... Vineland
R. Gregory Sachs, M.D. (1985) ..... Summit
Jesse Schulman, M.D. (1986) ..... Lakewood
Jeffrey M. Solomon, M.D. (1987) ..... Vineland
Mrs. Paul J. Hirsch, *Auxiliary Member* (1985) ..... Bridgewater
Harry M. Carnes, M.D., *Second Vice-President, Ex-officio Member* ..... Audubon
Frank J. Malta, M.D., *Consultant* ..... Toms River
Frank J. Primich, M.D., *Consultant* ..... West New York

SPECIAL COMMITTEES

Committee on Biomedical Ethics
(Staff Liaison, June O'Hare)

David Eckstein, M.D., *Chairman* ..... Trenton
James L. Breen, M.D. ..... Livingston
John P. Capelli, M.D. ..... Haddonfield
Joseph F. Fennelly, M.D. ..... Madison
Robert V. P. Hutter, M.D. ..... Livingston
Rudolf E. Schwaeble, M.D. ..... Mendham
Arthur Winter, M.D. ..... Livingston
Benjamin Wilfond, *Student Representative* ..... South Orange
Robert C. Cassidy, Ph.D., *Consultant* ..... New Brunswick
Russell L. McIntyre, Th.D., *Consultant* ..... Piscataway

Committee on Drug and Alcohol Abuse
(Staff Liaison, Martin E. Johnson)

Daniel P. Greenfield, M.D., *Chairman* ..... Short Hills
William J. Annitto, M.D. ..... Summit
Jorge L. Bascara, M.D. ..... Trenton
David I. Canavan, M.D. ..... Lawrenceville
Thomas R. Houseknecht, M.D. ..... Moorestown
Richard M. Liss, M.D. ..... Manville
Lawrence L. Livornese, M.D. ..... Middlesex
Edwin A. Turner, Jr., M.D. ..... Upper Saddle River
James S. Wales, Jr., M.D. ..... Perth Amboy
Matt Martin, *Consultant* ..... Trenton
Alfred E. Palmieri, M.D. *Consultant* ..... Clifton
Riley Regan, *Consultant* ..... Trenton
Loretta B. Ridolfi, R.P., *Consultant* ..... Trenton
Richard J. Russo, M.S.P.H., *Consultant* ..... Trenton
Robert Warden, D.O., *Consultant* ..... Stratford

Committee on Emergency Medical Care
(Staff Liaison, Joseph C. Lucci)

Rudolf E. Schwaeble, M.D., *Chairman* ..... Mendham
John A. Flood, M.D., *Vice-Chairman* ..... Trenton
Clifford B. Blasi, M.D. ..... Sea Girt
Ames L. Filippone, Jr., M.D. ..... Morristown
Ronald L. Franz, M.D. ..... Morrisville, PA
Jack R. Karel, M.D. ..... Verona
Dorson S. Mills, M.D. ..... Elmer
Robert L. Wegryn, M.D. ..... Elizabeth
David A. Halsey, *Student Representative* ..... Haddonfield
Joseph Kavanaugh, *Consultant* ..... Martinsville
Allen M. Koplin, M.D., *Consultant* ..... Trenton
Henry R. Liss, M.D., *Consultant* ..... Chatham
Ellsworth Havens, *Consultant* ..... Princeton

Committee on Impaired Physicians
(Staff Liaison, David I. Canavan, M.D.)

Boris G. Ivovich, M.D., *Chairman* ..... Clinton
Lee Allen ..... North Andover
Lawrence F. Barnet, M.D. ..... Paterson
Ann Beams ..... Cranford
Warren I. Brandwine, D.O. ..... Cherry Hill
Albert M. Bromberg, M.D. ..... Springfield
Edward M. Coe, M.D. ..... Cranford
Sheila Walsh Cogan, M.D. ..... Red Bank
A. Vincent DeRobbio, M.D. ..... Newark
Paul C. Fagen, M.D. ..... Montclair
Ronald I. Forster, M.D. ..... Union
Joseph R. Fontanella, M.D. ..... Point Pleasant
Joseph Giannasio, M.D. ..... Jersey City
Mark S. Gold, M.D. ..... Summit
Jerrold Goldstein, D.O. ..... Far Hills
Daniel P. Greenfield, M.D. ..... Short Hills
A. Starr Ingram, M.D. ..... Westfield
Alvin Kaplan, M.D. ..... Bound Brook
Wilbur F. Kell, D.O. ..... Somerdale
Doulat Keswani, M.D. ..... Ridgewood

Andrew J.V. Klein, M.D. ..... Orange
Anthony Komninos, M.D. ..... Morristown
Thomas J. Liddy, M.D. ..... Livingston
Leonard Liebowitz, M.D. ..... Old Bridge
George W. Lutz, M.D. ..... Somerville
James Manlandro, DO.O ..... Cape May Court House
Herbert T. McBride, M.D. ..... Toms River
Michael J. McCarthy, M.D. ..... Raritan
Arthur McLellan, M.D. ..... Summit
George J. Mellendick, M.D. ..... Perth Amboy
Rita Roslyn Newman, M.D. ..... Short Hills
Josephine Pesaresi ..... Hackensack
George Pierson, D.O. ..... Sparta
Marcus E. Sanford, M.D. ..... Somerville
Ward M. Schultz, M.D. ..... New Providence
Frank C. Snope, M.D. ..... Piscataway
Harvey D. Strassman, M.D. ..... Camden
William C. Van Ost, M.D. ..... Englewood
Robert M. Warden, D.O. ..... Stratford

Committee on Long-Range Planning Development
(Staff Liaison, Diana C. Gore)

Bernard Robins, M.D., *Chairman* (1986) ..... Springfield
Alfred A. Alessi, M.D. (1987) ..... Hackensack
William J. D'Elia, M.D. (1986) ..... Spring Lake
Philip J. LoPresti, M.D. (1987) ..... Haddon Heights
Thomas E. Mattingly, Jr., M.D. (1985) ..... Mount Holly
Frank R. Romano, Sr., M.D. (1986) ..... Dunellen
L. Arne Skilbred, M.D., (1986) ..... Glen Ridge

Committee on Maternal and Child Care
(Staff Liaison, Joseph C. Lucci)

Peter A. Beaugard, M.D. *Chairman* ..... Flemington
Gerard F. Hansen, M.D., *Vice-Chairman* ..... Hackensack
Caterina A. Gregori, M.D. ..... Livingston
John T. Harrigan, M.D. ..... New Brunswick
Thomas A. Noone, M.D. ..... Haddonfield
Thomas R. C. Sisson, M.D. ..... Perth Amboy
James P. Thompson, M.D. ..... Upper Montclair
William M. Unwin, *Student Representative* ..... Highland Park
George J. Halpin, M.D., *Consultant* ..... Trenton

Committee on Medical Aspects of Sports
(Staff Liaison, Joseph C. Lucci)

Christine E. Haycock, M.D., *Chairman* ..... Newark
Frank L. Barham, M.D. ..... Trenton
Norman W. Garwood, M.D. ..... Crosswicks
Paul J. Hirsch, M.D., *Treasurer* ..... Bridgewater
Glenn P. Lambert, M.D. ..... Flemington
Allan M. Levy, M.D. ..... Westwood
Vincent McInerney, M.D. ..... Paterson
Max M. Novich, M.D. ..... Perth Amboy
Benjamin I. Smolenski, M.D. ..... Mount Laurel
Peter Hyans, *Student Representative* ..... Piscataway
Sarah Dougherty, *Consultant* ..... Trenton
Abner West, *Consultant* ..... Elizabeth

Committee on Peer Review (DRG Appeals)
(Staff Liaison, Vincent A. Maressa)

William A. Dwyer, Jr., M.D., *Chairman* ..... Wayne
Paul I. Bookstaver, M.D. ..... Saddle Brook
Donald P. Burt, M.D. ..... Parsippany
Phillip Davison, M.D. ..... Roselle
Charles E. Dooley, Jr., M.D. ..... Springfield
Joseph W. Fleisher, M.D. ..... Springfield
D. D. Griffith, M.D. ..... East Brunswick
Charles Harris, M.D. ..... Toms River
Alvin I. Kaplan, M.D. ..... Bound Brook
Mohammad Khan, M.D. ..... Trenton
Francis J. Lumia, M.D. ..... Browns Mills
Nelson Manowitz, M.D. ..... Springfield
Alan W. Robbins, M.D. ..... Freehold
Mark Stern, M.D. ..... Cherry Hill
Robert J. Weierman, M.D. ..... South Orange
Michael E. Beams, D.O., *Consultant* ..... Cranford
Louis Scibetta, *Consultant* ..... Princeton

Committee on Retirement Plan for Physicians
(Staff Liaison, Joseph C. Lucci)

Nicholas E. Marchione, M.D., *Chairman* ..... Vinelan
Paul J. Kreutz, M.D. ..... Elizabet
Jack William P. Love, M.D. ..... Woodbur
Henry J. Mineur, M.D. ..... Westfiel
Robert E. Steward, M.D. ..... North Brunswic

SPECIAL COMMITTEE TO COUNCIL ON MEDICAL SERVICES

Committee on Occupational Health, Worker's Compensation, and Rehabilitation
(Staff Liaision, Joseph C. Lucci)

George P. Bisgeier, M.D., *Chairman* ..... Newar
Andrew G. Hudacek, M.D., *Vice-Chairman* ..... Morristow
Maurice E. Goldman, M.D. ..... New York, N
J. Campbell Howard, M.D. ..... Mountainsid
Michael N. Jennings, M.D. ..... Somervill
Bertram M. Kummel, M.D. ..... Morristow
Edwin A. Turner, Jr., M.D. ..... Upper Saddle Rive
Mathilda R. Vaschak, M.D. ..... North Plainfiel
John S. Tobin, M.D., *Consultant* ..... Princeto

SPECIAL COMMITTEES TO COUNCIL ON PUBLIC HEALTH

Committee on Cancer Control
(Staff Liaison, Joseph C. Lucci)

Benjamin F. Rush, Jr., M.D., *Chairman* ..... Newar
Donald Brief, M.D. ..... Millbur
Sherman Garrison, M.D. ..... Bridgeto
George J. Hill, M.D. ..... Newar
Warren H. Knauer, M.D. ..... Hillsid
Albert A. Pineda, M.D. ..... Clifto
Harvey Rothberg, M.D. ..... Princeto
Elissa J. Santoro, M.D. ..... Irvingto
Eva B. Stahl, M.D. ..... Highland Par
Harvey P. Yeager, M.D. ..... Millbur

Committee on Child Health
(Staff Liaison, Joseph C. Lucci)

Glenn P. Lambert, M.D., *Chairman* ..... Flemingto
James Q. Atkinson, M.D. ..... Vincentow
Thomas F. Bejgrowicz, M.D. ..... Linde
Anthony Brickman, M.D. ..... Trento
William J. Farley, M.D. ..... Briel
Harry E. Turse, M.D. ..... Medfo
Catherine P. Bush, *Student Representative* .. Wood-Ridg

Committee on Conservation of Vision
(Staff Liaison, Joseph C. Lucci)

Marc L. Engel, M.D., *Chairman* ..... Holmd
Malcolm H. Bloch, M.D. ..... Morristow
Alfonse A. Cinotti, M.D. ..... Jersey Ci
Samuel Diskan, M.D. ..... Atlantic Ci
Ivan H. Jacobs, M.D. ..... North Plainfie
Oram R. Kline, Jr., M.D. ..... Woodbu
Ralph A. Skowron, M.D. ..... Cherry H
Saul M. Tischler, M.D. ..... Cherry H
Marc L. Engel, M.D., *Consultant* ..... Holmd
Ivan H. Jacobs, M.D., *Consultant* ..... North Plainfie

Committee on Environmental Health
(Staff Liaison, Joseph C. Lucci)

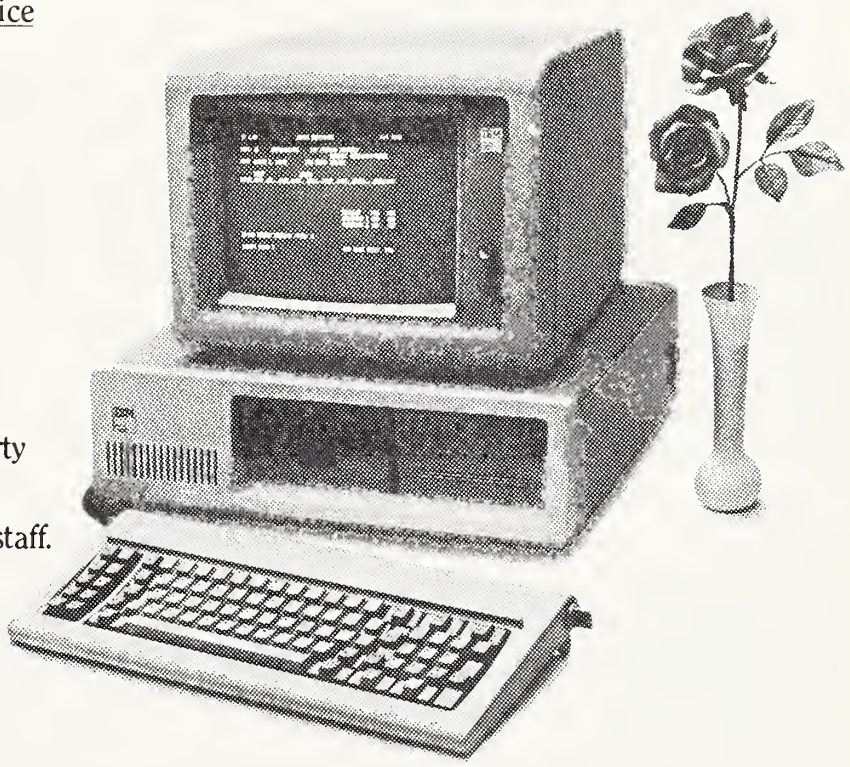
Philip J. G. Quigley, M.D., *Chairman* ..... Point Pleasant Bea
Seymour Charles, M.D. ..... Maplewo
Stanley R. Lane, M.D. ..... Moorestow
Richard H. Musgnug, M.D. ..... Medford Lak
E. Spencer Paisley, M.D. ..... Haddon Heigh
William I. Weiss, M.D. ..... Livingst
Meyer T. Weissman, M.D. ..... Cranbu
Bradley S. Panton, *Student Representative* ..... New Brunswi

ne IBM Personal Computer
tool for modern times
the Medical Office.

EDI-SCAN®, an Authorized IBM® Value-led Dealer for the Personal Computer

Comprehensive $8,995.00 MEDI-SCAN In-office
ng And Accounting System Includes:

- e IBM Personal Computer XT with 128K, Megabyte hard disk.
- e IBM Graphics Printer.
- EDI-SCAN software—customized for your ctice, including procedure numbers for state encies. Generates accounting reports, nprehensive patient statements, insurance d third party forms.
- tional electronic paperless billing to third party encies, where applicable.
- ining—Complete in-office training for your staff.
- pport—"HOT-LINE" 800 number for ntinuous support.



EDI-SCAN Single Source pport System

DI-SCAN'S unique, comprehensive hardware and software maintenance agreement guarantees continuing ce and repair, system updates and additional customization, plus in-office training—all from one source. Our training consultants and technicians are dedicated to giving you the best possible service.

Personal Computer XTs are in stock in our local warehouses ready to be immediately installed. Over three dred physicians are using the MEDI-SCAN System—join them in making the IBM PC-XT "A tool for modern s in the medical office."

Networking available for group practices and clinics

---

would like to know more about the MEDI-SCAN stem on the IBM Personal Computer XT.

_____

ldress _____

ty_____ State_____ Zip____

none (____) _____

Or call: 800-922-1021
In MA: 800-462-1009

Send to: **MEDI-SCAN**
90 Madison Street, Worcester, MA 01608

IBM Authorized Value Added Dealer Personal Computers

MEDI-SCAN

rvice centers currently in: *New England* · *Mid Atlantic States* · *Mid Western States* · *California* · *Texas*

EDI-SCAN is a registered trademark of PAL Assoc. Inc.
Associates is an Authorized IBM Value-Added Dealer for the Personal Computer.
M is a registered trademark of International Business Machines Corporation.

Statement of Ownership, Management, and Circulation

(Required by 39 U.S.C. 3685)

1. Title of Publication: THE JOURNAL of the Medical Society of New Jersey.

1A. Publication No.: 0025-7524.

2. Date of Filing: September 28, 1984.

3. Frequency of Issue: Monthly.

3A. No. of Issues Published Annually: 12 + 1 = 13.

3B. Annual Subscription Price: $20.00.

4. Location of Known Office of Publication: 2 Princess Road, Lawrenceville, Mercer County, NJ 08648.

5. Location of the Headquarters or General Business Office of the Publisher: 2 Princess Road, Lawrenceville, Mercer County, NJ 08648.

6. Names and addresses of publisher, editor, and managing editor: Publisher, Medical Society of New Jersey, 2 Princess Road, Lawrenceville, NJ 08648. Editor, Arthur Krosnick, M.D., 2 Princess Road, Lawrenceville, NJ 08648. Managing Editor, Geraldine R. Hutner, 2 Princess Road, Lawrenceville, NJ 08648.

7. Owner (if owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given. If the publication is published by a nonprofit organization, its name and address must be stated.): Medical Society of New Jersey, 2 Princess Road, Lawrenceville, NJ 08648 (a nonprofit corporation of New Jersey).

8. Known bondholders, mortgages, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages, or other securities: none (a nonprofit corporation of New Jersey).

9. For completion by nonprofit organization authorized to mail at special rates (Section 411.3, DMM only). The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes have not changed during preceding 12 months.

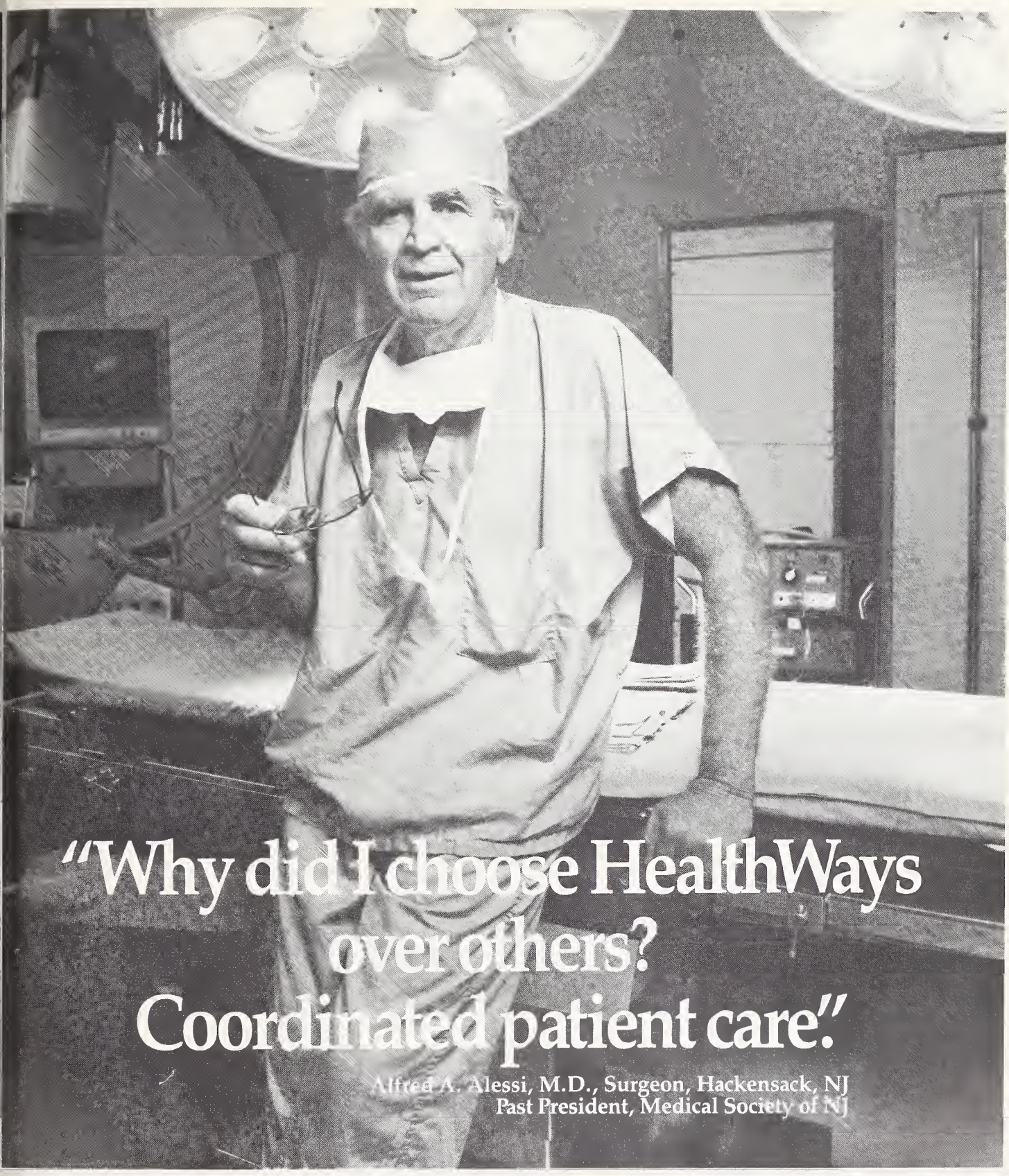
10. Extent and nature of circulation:

Extent and nature of circulation	Average no. copies each issue during preceding 12 months	Actual no. of copies of single issue published nearest to filing date
A. Total no. copies printed (net press run)	11,500	10,600
B. Paid circulation		
1. Sales through dealers and carriers, street vendors, and counter sales	—	—
2. Mail subscriptions	9,605	9,755
C. Total paid circulation (sum of B1 and B2)	9,605	9,755
D. Free distribution by mail carrier or other means—samples, complimentary, and other free copies	1,671	609
E. Total distribution (sum of C and D)	11,276	10,364
F. Copies not distributed		
1. Office use, left-over, unaccounted, spoiled after printing	224	236
2. Return from new agents	—	—
G. Total (sum of E, F1, and 2—should equal net press run shown in A)	11,500	10,600

11. I certify that the statements made by me above are correct and complete.

(signed) Arthur White
Director of Finance and Administrative Services

12. For completion by publishers mailing at the regular rates (Section 132.121, Postal Service Manual). 39 U.S.C. 3626 provides in pertinent part: "No person who would have been entitled to mail matter under former section 4359 of this title shall mail such matter at the rates provided under this subsection unless he files annually with the Postal Service a written request for permission to mail matters at such rates." In accordance with the provisions of this statute, I hereby request permission to mail the publication named in Item 1 at the phased postage rate presently authorized by 39 U.S.C. 3626 (signed).



"One of the main reasons I ıose to become a participating ealthWays physician was because HealthWays basic philosophy of ordinated patient care. As a spe-alist, this is of extreme importance me. I work closely with my pa-ents' primary care physicians who ıow them intimately since they e them on a regular basis. This ıysician cooperation delivers the ost complete care possible without duplication or disparities.

In addition, since HealthWays covers its members for surgical procedures in the setting most appropriate, I can even perform simple surgery in my own office when hospitalization really isn't necessary. That makes inordinate sense for many patients and for me.

There's a great deal of logic to HealthWays as a health plan. And a great deal of logic for physicians to become participants."

To learn all the HealthWays benefits for you and your patients, call Jon Marsicano, M.D., Vice President, Medical Affairs, at 1-800-624-0720.

HealthWays
YOUR WAY TO BETTER HEALTH CARE

© 1984 HealthWays, Inc.

ACUPUNCTURE IN CLINICAL PRACTICE

N.Y. State Boards of Medicine & Dentistry 25-hour accredited seminar and workshop on the latest theories & techniques of manual & electro-acupuncture and TENS, applicable toward the 200-hour requirement for certification, will be given for licensed clinicians (with or without prior training) during the weekend of Dec. 14-16, 1984 and again the weekend of Feb. 1-3, 1985 at the Barbizon Plaza Hotel, New York City. Co-sponsored by the International College of Acupuncture & Electro-Therapeutics, its official journal, Acupuncture & Electro-Therap. Res., Int.J. (published by Pergamon Press and indexed in 15 major indexing periodicals; INDEX MEDICUS, etc.), the Heart Disease Research Foundation and the Neuroscience Dept. of Long Island College Hospital, Pharmacology Dept. of The Chicago Medical School. Also eligible for AMA/CME credit. For information, contact Y. Omura, M.D., ScD., 800 Riverside Drive (8-1), NYC 10032. Tel: (212) 781-6262 or (212) WA8-0658, or Saul Heller, M.D., Tel: (212) 838-7514.

NEW JERSEY SOCIETY OF PATHOLOGISTS

34TH ANNUAL SLIDE SEMINAR

SATURDAY, NOVEMBER 17, 1984
AT
UMDNJ-RUTGERS MEDICAL SCHOOL
PISCATAWAY, NEW JERSEY
9:00 A.M.-1:00 P.M.
ON

SURGICAL PATHOLOGY OF THE BREAST: DIAGNOSIS AND THERAPEUTIC IMPLICATIONS

SPEAKER:

Robert V.P. Hutter, M.D.
Chairman, Department of Pathology
St. Barnabas Medical Center, Livingston
Adjunct Professor of Pathology,
College of Physicians & Surgeons,
Columbia University

A wide variety of cases submitted by members will be discussed. Members will receive slide sets and case histories. A limited number of slide sets are available to non-members for $35.00.

OBJECTIVE: The program is designed for diagnostic surgical pathologists. The objectives are to become familiar with specific types of diagnostic problems and rare types of breast cancer, to emphasize the clinical-pathological interaction and to discuss the role of the pathologist in the management of patients with these types of lesions.

For Further Information Contact:
Cathy Gillmer, Executive Secretary
New Jersey Society of Pathologists
Two Princess Road, Lawrenceville, NJ 08648
Phone (609) 896-1717

The Academy of Medicine of New Jersey
presents
a symposium on

Medical & Surgical Management of Cerebrovascular Insufficiency

Saturday, November 17, 1984
8:00 a.m.-1:00 p.m.
at
UMDNJ-New Jersey Medical School, Newark

This course is intended for family physicians and surgeons, internists and neurologists interested in the care of patients with cerebrovascular insufficiency. In addition, these topics will be of value to vascular technologists interested in Noninvasive Vascular Laboratory testing.

LEARNING OBJECTIVE: To review the diagnostic and medical management of cerebrovascular insufficiency. To become familiar with diagnostic testing to include the role of CT & NMR scanning and noninvasive vascular laboratory studies. To become familiar with the technical considerations and results of extracranial to intracranial bypass and carotid endarterectomy in the treatment of patients with cerebrovascular insufficiency. To review and be familiar with the medical and surgical management of asystemic extracranial carotid occlusive disease.

For further information contact:
EXECUTIVE OFFICES
The Academy of Medicine of New Jersey
Two Princess Road
Lawrenceville, NJ 08648
(609) 896-1717

The Academy of Medicine of New Jersey
presents

A SYMPOSIUM ON CONTROVERSIES IN GERIATRICS

on
WEDNESDAY, NOVEMBER 28, 1984
1:00 p.m.-5:00 p.m.
at
MSNJ HEADQUARTERS BUILDING
Lawrenceville, New Jersey

The symposium will identify specific medical and social problems of the aged. In addition we plan to determine who should be in charge of the elderly: a primary care physician, or a specialist in geriatrics. Finally we plan to decide whether or not geriatrics is a specialty of medicine. The program is designed for internists, family practitioners, administrators of long term care facilities and other interested professionals.

For further information contact:
EXECUTIVE OFFICES
The Academy of Medicine of New Jersey
Two Princess Road
Lawrenceville, NJ 08648
(201) 896-1717

CME CALENDAR

The following is a list of continuing medical education courses for the next two months. Contact the sponsoring organization for further information.

NESTHESIOLOGY

an.

2 **Dinner Meeting**
6-9 P.M.—Ramada Inn, Clark
(NJ State Society of Anesthesiologists and AMNJ)

ARDIOLOGY

ec.

8 **Streptokinase and Percutaneous Transluminar Angioplasty**
12 noon—St. Mary's Hospital, Orange
(AMNJ)

EDICINE

ec.

4 **AIDS**
9 A.M.—Holy Name Hospital, Teaneck
(AMNJ)

4 **Research in Group B Streptococcal Disease**
8:30-9:30 A.M.—Newark Beth Israel Medical Center
(Newark Beth Israel Medical Center and AMNJ)

5 **AIDS**
9 A.M.—Warren Hospital, Phillipsburg
(AMNJ)

5 **Clinical Abstract Meeting**
1-5 P.M.—The Manor, West Orange
(Oncology Society of NJ and AMNJ)

5 **Endocrine Conferences**
12 3:30-5 P.M.—Rotates between
19 Newark Beth Israel Medical Center,
26 University Hospital, United Hospitals Medical Center, Newark, and VA Medical Center, East Orange
(Endocrinology Section and AMNJ)

5 **Medical Grand Rounds**
12 12 noon-1 P.M.—Rutgers Medical
19 School, Medical Education Bldg., New Brunswick
(UMDNJ and AMNJ)

5 **Medicine Morbidity and Mortality Conference**
8-9 A.M.—Rutgers Medical School, Medical Education Bldg., New Brunswick
(UMDNJ and AMNJ)

6 **Management of Congenital Infections**
9 A.M.—Freehold Area Hospital
(AMNJ)

6 **Immunoregulation: Basic**
13 **Concepts and Applications**
4-6 P.M.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

12 **Clinical Immunology**
1 P.M.—VA Medical Center, Lyons
(AMNJ)

12 **What Is New in Allergy?**
8-9:30 P.M.—Schering Corporation, Kenilworth
(NJ Allergy Society, Schering Corp., and AMNJ)

13 **Management of Abdominal Emergencies**
11 A.M.—St. Joseph's Hospital and Medical Center, Paterson
(AMNJ)

13 **The Prevention and Reversibility of Heart Disease**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

13 **Indications, Techniques, and Results in Coronary Thrombolysis**
5-7:30 P.M.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

Jan.

2 **Internal Medicine Review Course**
9 3-6 P.M.—Overlook Hospital,
16 Summit
23 *(Overlook Hospital and AMNJ)*
30

2 **Endocrine Conferences**
9 3:30-5 P.M.—Rotates between
16 Newark Beth Israel Medical Center,
23 University Hospital, United
30 Hospitals Medical Center, Newark, and VA Medical Center, East Orange
(Endocrinology Section and AMNJ)

2 **Medical Grand Rounds**
9 12 noon-1 P.M.—Rutgers Medical
16 School, Medical Education Bldg.,
23 New Brunswick
30 *(UMDNJ and AMNJ)*

2 **Medicine Morbidity and Mortality Conference**
8-9 A.M.—Rutgers Medical School, Medical Education Bldg., New Brunswick
(UMDNJ and AMNJ)

2 **Immunoregulation: Basic**
10 **Concepts and Applications**
17 4-6 P.M.—Institute for Medical
24 Research, Copewood St., Camden
31 *(Institute for Medical Research and AMNJ)*

8 **Melanoma Precursors**
8-10 P.M.—Schering Corp., Kenilworth
(NJ Dermatological Society and AMNJ)

8 **AIDS**
8-9 A.M.—Wayne General Hospital
(AMNJ)

9 **AIDS**
1-2 P.M.—VA Hospital, Lyons
(AMNJ)

15 **Cocaine Abuse**
12 noon—St. Mary's Hospital, Orange
(AMNJ)

16 **Dermatological Conference**
6-8 P.M.—Rutgers Community Health Plan, U.S. Hwy. 1 & Rt. 18, New Brunswick
(UMDNJ-Rutgers Medical School and AMNJ)

17 **New Concepts in Digoxin Metabolism**
11 A.M.-12 noon—St. Joseph's Hospital, Paterson
(St. Joseph's Hospital and Medical Center and AMNJ)

17 **Geriatrics**
3 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

17 **Whither Multiple Sclerosis?**
5-7:30 P.M.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

30 **Mitral Valve Prolapse**
1-2:30 P.M.—VA Medical Center, Lyons, Bldg. 93
(VA Medical Center and AMNJ)

NEUROLOGY/PSYCHIATRY

Dec.

3 **Survival Guilt with Somatic Symptoms**
8:15-10:30 P.M.—4 Garden Place, Nutley
(Essex Psychiatric Seminar and AMNJ)

3 **When the Patient Abuses Drugs: Skills for the Outpatient Therapist**
1-4 P.M.—Fair Oaks Hospital, Summit
(Fair Oaks Hospital and AMNJ)

6 **Medical Hypnosis Course**
13 4-8 P.M.—Carrier Foundation, Belle Meade
(Carrier Foundation and AMNJ)

12 **Sleep Disorders**
1:30-2:30 P.M.—Rutgers Community Health Plan, 57 U.S. Hwy. #1, New Brunswick
(Rutgers Community Health Plan and AMNJ)

13 **Becoming a Psychotherapist**
12 noon-1 P.M.—Carrier



American Society For Parenteral & Enteral Nutrition®

9TH CLINICAL CONGRESS

January 21-24, 1985

FONTAINEBLEAU HOTEL
MIAMI BEACH, FLORIDA

For more information contact: A.S.P.E.N., 8605 Cameron Street, Suite 500, Silver Spring, MD 20910, (202) 638-5881.

1985 CME CRUISE/CONFERENCES ON SELECTED MEDICAL TOPICS

Caribbean, Mexican, Hawaiian, Alaskan, Mediterranean. 7-14 days year-round. Approved for 20-24 CME Cat. 1 credits (AMA/PRA) & AAFP prescribed credit. Distinguished professors. FLY ROUNDTRIP FREE ON CARIBBEAN, MEXICAN, & ALASKAN CRUISES. Execellent group fares on finest ships. Registration limited. Pre-scheduled in compliance with present IRS requirements.

Information: International Conferences, 189 Lodge Ave., Huntington Station, N.Y. 11746. (516) 549-0869.

PEDIATRIC UPDATE 1985

Hotel de Paris, Monte Carlo, Monaco
March 16-24, 1985

Sponsored by: Department of Pediatrics, Schneide Children's Hospital, Long Island Jewish-Hillside Medi cal Center, New Hyde Park, NY. Faculty: Phili Lanzkowsky, M.D., Jean Alexander Cortner, M.D., Jan G. Schaller, M.D., and Irving Schulman, M.D. Credits 21 hours Category 1 ACCME, AMA and AAFP.

Information: Continuing Education Coordinator, Lon Island Jewish-Hillside Medical Center, New Hyde Park NY 11042, (718) 470-2114.



LIKOFF CARDIOVASCULAR INSTITUTE

of Hahnemann Medical College & Hospital

230 N. Broad Street, Philadelphia, Pennsylvania 19102 (215) 448-8063

CARDIOLOGY UPDATE. . .

IS DESIGNED FOR THE PHYSICIAN AND PROVIDES AN INTENSIVE SURVEY OF THE CURRENT STATUS OF CLINICAL CARDIOLOGY. . .

WEDNESDAY, DECEMBER 5, 1984

HYPERTENSION

MODERATOR: DAVID T. LOWENTHAL, M.D.

3:00	Case Presentation	*Stanley Spitzer, M.D.*
3:30	Should Mild Hypertension be Treated?	*Sheldon R. Bender, M.D.*
4:00	What is the Step-Care Management?	*David T. Lowenthal, M.D.*
4:30	Managing Hypertensive Emergencies	*Stuart Snyder, M.D.*
5:00	Managing Resistent Hypertension: What are the Benefits of Antihypertensive Therapy?	*David T. Lowenthal, M.D.*

LECTURE HALL "A"—2nd floor New College Building, Hahnemann University
15th and Vine Streets, Philadelphia, PA

• NO REGISTRATION FEE • NO ADVANCE REGISTRATION REQUIRED •
• CME CATEGORY I CREDITS CERTIFIED •
WINE & CHEESE SERVED FOLLOWING CONFERENCE

Foundation, Belle Meade
(Carrier Foundation and AMNJ)

Child Sexual Abuse
8:30 A.M.-5 P.M.—Fair Oaks Hospital, Summit
(Fair Oaks Hospital and AMNJ)

Coordination of Psychiatric Treatment in the Hospital and Community
3 P.M.—Ancora Psychiatric Hospital, Hammonton
(Ancora Psychiatric Hospital)

Lecture Series
8:30-10:30 P.M.—301 Broad Ave., Englewood
(NJ Psychoanalytic Society and AMNJ)

n.

Case Seminars and Supervision to Improve Psychotherapeutic Techniques
8-10 P.M.—310 Harding Dr., South Orange
(Advanced Psychiatric Study Group and AMNJ)

Sexual Obsession in a 20-Year Marriage
8:15-10:30 P.M.—111 Ridgewood Ave., Glen Ridge
(Essex Psychiatric Seminar and AMNJ)

Neurology: New Treatments of Cerebrovascular Disease
2 P.M.—John E. Runnells Hospital, Berkeley Heights
(AMNJ)

21 **Lecture Series**
8:30-10:30 P.M.—301 Broad Ave., Englewood
(NJ Psychoanalytic Society and AMNJ)

OBSTETRICS/GYNECOLOGY

Dec.

3 **Prophylactic Mastectomy and Treatment of the Second Breast**
8 A.M.-5 P.M.—UMDNJ-Rutgers Medical School, Medical Education Bldg., New Brunswick
(UMDNJ-Rutgers Medical School)

4 **Psychosocial Issues and Interactions in Breast Disease**
9 A.M.-4 P.M.—UMDNJ-Rutgers Medical School, Medical Education Bldg., New Brunswick
(UMDNJ-Rutgers Medical School)

PEDIATRICS

Jan.

11 **Extracorporeal Membrane Oxygenation for Neonatal Respiratory Failure**
8-9:30 A.M.—Overlook Hospital, Summit
(Overlook Hospital and AMNJ)

COME JOIN US

The 219th Annual Meeting Medical Society of New Jersey

Americana Host Farm Resort
Lancaster, Pennsylvania

May 2-5, 1985

RADIOLOGY

Dec.

5 **NMR—Clinical Imaging**
1:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)

15 **Topic To Be Announced**
7:30-10 P.M.—Saint Barnabas Medical Center, Livingston
(NJ Institute of Ultrasound in Medicine and AMNJ)

20 **Radiology Meeting**
7:30 P.M.—Saint Barnabas Medical Center, Livingston
(Radiological Society of NJ and AMNJ)

27 **Visiting Professorship Program**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(Saint Barnabas Medical Center and AMNJ)

Jan.

16 **Combined Modality Therapy in the Treatment of Unresectable Carcinoma of the Pancreas**
6:30-10 P.M.—The Manor, West Orange
(Radiotherapy Section and AMNJ)

17 **Multimodality Approach to Renal Disease**
7:30-10 P.M.—Saint Barnabas Medical Center, Livingston
(NJ Institute of Ultrasound in Medicine and AMNJ)

SURGERY

Dec.

1 **Clinical Meeting**
All Day Session—UMDNJ-NJ Medical School, Newark
(NJ Chapter, American College of Surgeons and AMNJ)

6 **Surgical Treatment of Morbid Obesity**
12 noon—West Jersey Hospital, Camden
(AMNJ)

14 **Surgical Emergencies in the Newborn**
8-9:30 A.M.—Overlook Hospital, Summit
(Overlook Hospital and AMNJ)

18 **Arterial Clot Lysis Using Streptokinase**
8-10 P.M.—Englewood Club, Englewood
(Englewood Surgical Society and AMNJ)

Jan.

22 **Malignant Hyperthermia**
8-10 P.M.—Englewood Club, Englewood
(Englewood Surg. Soc. and AMNJ)

MISCELLANEOUS

Dec.

5 **DRG—Cost Containment**
10:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

29 **Nuclear Holocaust Prevention**
12 noon-1 P.M.—Carrier Foundation, Belle Meade
(Carrier Foundation and AMNJ)

CLIP & SA

The Medical Society of New Jersey and the Healthcare Information Network

Television Program Guide

September-May

Closed circuit television programs related to issues and concerns of physician members of MSNJ.

- **PRESIDENT'S FORUM:** hosted by Frank Y. Watson, M.D., President, MSNJ
- **THE IMPAIRED PHYSICIAN:** hosted by David I. Canavan, M.D., Director, Impaired Physicians Program, MSNJ
- **STATE OF THE ART:** hosted by Howard D. Slobodien, M.D., Past President, MSNJ

Programs will be featured the first, second, and third Tuesday of each month at 1:00 P.M. There will an 800 number for viewer participation.

Presented solely through those New Jersey hospitals which are subscribers to the **HIN** closed circ television network. A listing of participating hospitals is on the bottom of this page.

For additional information or comments, contact the Medical Society of New Jersey, Department of Spec Projects, A. Ronald Rouse, Director.

President's Forum

Frank Y. Watson, M.D., President of the Medical Society of New Jersey, will host this program with selected members from the Board of Trustees and appropriate Council and Committee Chairpersons who will present information discussed at the previous Board meetings.

Air time for this program is financed by the Medical Society of New Jersey.

Tuesday, October 2, 1984
Tuesday, November 6, 1984
Tuesday, December 4, 1984
Tuesday, January 1, 1985
Tuesday, February 5, 1985
Tuesday, March 5, 1985
Tuesday, April 2, 1985
Tuesday, May 7, 1985

The Impaired Physician

Air time for this program is financed by the Health Care Insurance Exchange (HCIE) and the Princeton Insurance Company (PIC).

Tuesday, September 11, 1984
"Acute Case of the Impaired Physician"

Tuesday, October 9, 1984
"Rehabilitation Programs"

Tuesday, November 13, 1984
"Aftercare"

Tuesday, December 11, 1984
"The Family and The Disease"

Tuesday, January 8, 1985
"Support Groups"

Tuesday, February 12, 1985
"Problems of Re-Entry"

Tuesday, March 12, 1985
"Followup/Monitoring"

Tuesday, April 9, 1985
"Recidivism/Special Problems"

State of the Art

Air time for this program is finan by the Medical Society of New Jers

Tuesday, October 16, 1984
Professional Liability
James E. George, M.D., J.D.
and
Mr. Adam Wilczek

Tuesday, November 20, 1984
Continuing Medical Education
Paul Hirsch, M.D.,
Edwin Messey, M.D.
and
Robert Rigolosi, M.D.

Tuesday, December 18, 1984
MSNJ Legislative Activities
Mr. Joseph Katz
and
Mr. Clark Martin

The following programs will be nounced at a later date:

Tuesday, January 15, 1985
Tuesday, February 19, 1985
Tuesday, March 19, 1985
Tuesday, April 16, 1985
Tuesday, May 21, 1985

Participating Hospitals*: Beth Israel Hospital; Freehold Area Hospital; Memorial General Hospital; M ristown Memorial Hospital; Northern Ocean Hospital System, Inc.; Pascack Valley Hospital; Saint Elizab Hospital; Saint Mary's Hospital; Saint Peter's Medical Center; and Underwood-Memorial Hospital.

Hospitals Declaring a Preliminary Interest: Atlantic City Medical Center; ACMC-Mainland Division; Be Bacharach Rehab. Hospital; Bridgeton Hospital; Carrier Foundation; Clara Maass Medical Center; Co munity Memorial Hospital; Deborah Heart & Lung Center; Englewood Hospital Association; Hackensa Medical Center; Holy Name Hospital; Hospital Center at Orange; John F. Kennedy Medical Ctr.; KMH/UM Stratford Division; Kessler Institute for Rehab.; Monmouth Medical Center; Muhlenberg Hospital; New Beth Israel Medical Ctr.; Newton Memorial Hospital; Riverside Hospital; Salem County Memorial Hospi and Saint Clare's Hospital; Saint Francis Medical Center; Warren Hospital; West Hudson Hospital; and W Jersey Hospital-Northern Division.

*Listing of hospitals may have changed since this printing.

CLIP & SA

ETTERS TO THE DITOR

Actinomycosis; Faithful Worker; Length of Stay

ctinomycosis

August 20, 1984

ar Doctor Krosnick:

would like to report two pediatric ses of thoracic actinomycosis, an ncommon entity.

1. An eight-year-old male was in od health until he fell onto the ndlebars of his bicycle producing abrasion of his left lateral thorax. in and erythema developed and en he visited the surgical clinic ere a debridement was per-med. He returned two weeks later cause of drainage at the site. A lture and smear were obtained. ie smear revealed sulfur granules ong the pus cells. He was ad-itted and started on intravenous gh-dose penicillin; 1,000,000 its IV q 6h. The culture grew *Ac-omyces israelii*. Drainage con-ued and x-ray examination owed a progressive empyema. He en underwent a thoracotomy ich led to a rapid resolution of the pyema. He was discharged and ntinued on oral phenoxymethyl nicillin 250 mg q 6h for one onth. Followup chest x-rays and ysical examination documented mplete recovery.

2. A 13-year-old male who has ffered from psychomotor retarda-n from birth was noted on physical examination to have a cystic mass of the left chest wall. A chest x-ray showed a pleural empyema. A thoracotomy was performed and chest tubes were placed for drainage. A gram stain of the material obtained at surgery showed sulfur granules and cultures grew *Actinomyces* species. He was placed on high-dose intravenous penicillin; 1,000,000 units IV q 4h for two weeks and showed gradual improvement. He was continued on oral phenoxymethyl penicillin 250 mg po q 6h for six weeks with subsequent complete resolution of the pleural reaction.

The second patient had the poor dental hygiene and malnutrition that has been associated with pulmonary infection with actinomycosis. The appearance of the mass was consistent with the "tunneling" described with actinomycosis's disregard of tissue planes.[1,3] Mass lesions have been reported in other cases.[3] The first patient was unusual in that infection had apparently spread from the skin to the pleura. He had been in otherwise excellent health previously. Both patients' management required the placement of chest tubes which usually are not required in treating this entity. In previous reports, the length of treatment with oral penicillin following high-dose intravenous penicillin had not been well established.

(signed) Robert B. Baker, M.D.

REFERENCES

1. Rose HD, Varkey B, Kesevan KCP: Thoracic actinomycosis caused by *Actinomyces meyeri*. *Am Rev Resp Dis* 125:251-254, 1982.
2. Spinola SM, Bell RA, Henderson FW: Actinomycosis. *Am J Dis Child* 135:336-339, 1982.
3. Seaman WB: The case of the infected lung. *Hosp Prac* 23-26, 1982.
4. Harrison RN, et. al.: Acute actinomycotic empyema. *Thorax* 34:406-407, 1982.
5. Stanley TV: Deep actinomycosis in childhood. *Acta Ped Scand* 69:173-176, 1982.

Faithful Worker

August 23, 1984

Dear Doctor Krosnick:

I would like to call to your attention an item I think merits notice.

Joan Basic is Executive Secretary of Bergen County Medical Society and has worked faithfully in the Bergen County vineyard for more than 13 years. We just have been notified by the American Society of Association Executives of Washington, D.C., that the ASAE Certification Commission has presented her with the Certified Association Executive Award.

To put this in the proper perspective, let me point out that there are 825 members of the American Association of Medical Society Executives, but only 34 are CAEs. And, indeed, there are no medical executives in New Jersey who have achieved CAE status. The examination itself is a grueling affair and takes a whole day. Most of the execs who stand for the examination usually study for two years in advance.

Mrs. Basic also is the paid Executive Secretary of our Bergen County Auxiliary. To the best of my knowledge, she is the only paid County Auxiliary exec in the country.

We obviously are justly proud of Mrs. Basic's accomplishments.

(signed) George Willis
Executive Director
Bergen County Medical Society

Length of Stay

September 10, 1984

Dear Doctor Krosnick:

I have noticed a disturbing trend among physicians; more and more of them are equating quality of care in hospitalized patients with the length of stay in the hospital. The shorter the stay, the better the quality of care. Of all the people, physicians are accepting this myth as gospel. In almost any medical meeting, some physicians will get up and describe, in very flowery language, how in a certain diagnosis the hospital stay was reduced by half a day or so and will give a pat on the back of the medical staff for raising the quality of patient care.

With the onslaught of PSROs, PROs, HMOs, DRGs, and all the other abbreviated modalities of medical interferences, abbreviated stay in the hospital does not necessarily mean better quality of patient care. In some cases, an extra day or two in the hospital actually can improve the standard of life and health of the patient. Suddenly, we are being exposed to too much administrative medicine.

(signed) Jagdish C. Dang, M.D.

Breast Cancer; Classics of Cardiology; Handbook of Pediatric Primary Care

Breast Cancer: Diagnosis and Management, Vol. 1

Gianni Bonadonna, M.D., (ed). New York, NY, John Wiley & Sons, 1984. Pp. 347. Illustrated.

Dr. Bonadonna of the National Tumor Institute in Milan has gathered an impressive array of European and American cancer specialists; they have contributed a total of 17 chapters which purport to cover practically every aspect of the diagnosis and management of breast cancer from basic biology and pathology to surgery, chemotherapy, radiotherapy, and psychology.

Their stated aim was to provide a "distillation of current results" but unfortunately they produced a tedious textbook containing a voluminous amount of detailed information, much of which is only semi-distilled, if not raw.

Most clinicians who periodically assume a degree of responsibility for the diagnosis and management of this most common type of cancer readily would welcome a book containing the latest information, but this mistura of facts, opinions, and research findings tends to confuse, overwhelm, and even discourage those readers who already are not knowledgeable in their own specific areas of expertise.

The present volume, the first in a series dealing with cancer, cannot be recommended to anyone but the most sophisticated physician.

Jerome Abrams, M.D.

Classics of Cardiology, Volume Three

Callahan, Keys, and Key (eds). Malabar, FL, Robert Krieger Publishing Co., 1983. Pp. 623. Illustrated.

Classics in Cardiology, Volume 3 is a collection of 47 selected research manuscripts published between 1895 and 1954; the theme of these papers is cardiovascular diseases. Though many of the authors of these papers are recognized as venerable physician-scientists, some are not recognized readily; however, the nature of the contribution to medical science is in all cases.

The editors have prepared brief biographies of these authors. These vignettes acquaint the reader with the author and provide some framework for the significance of the research article then presented. The student of medical history will see these biographies as starting points for more indepth study. Of interest was the availability of the birth date for deriving the scientists' ages at the times of their significant contributions. The manuscripts are presented chronologically from the oldest (1895) to most recent (1954). The last three pages before the author index consist of a section of key references entitled, "History of Cardiology," providing additional sources for the person interested in further reading.

To what group of readers is this book directed? Individuals within the medical sciences who are history buffs certainly will want to read this book. Laypeople doing background medical science historical research, e.g. journalists, may find the book useful but not the manuscripts. The book might be useful as a text for studying protocol methodology and how it has or has not evolved over the past 90 years. Finally, this bo is ideal as a reference text in t medical library for the informati contained will not be out-of-da next year.

Robert M. MacMillan, M.

Handbook of Pediatric Primary Care, Second Edition

Chow, Durand, Feldman, and Mi New York, NY, John Wiley & So 1984. Pp. 1,300. ($36.95)

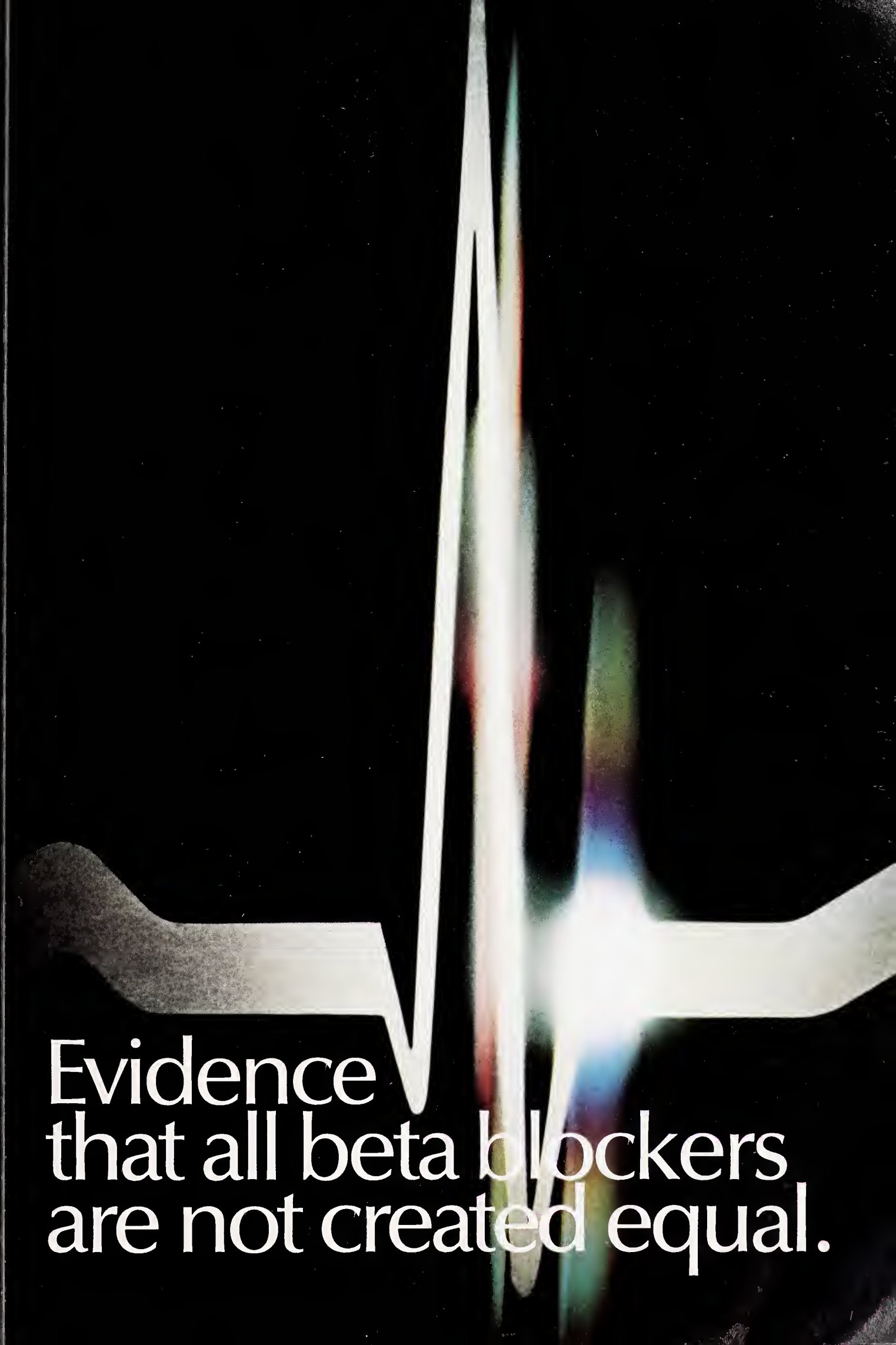
The purpose of this book is provide concise primary care pe atric information in handbook st The authors, all nurses, h directed their efforts primarily pediatric nurse practitioners.

The book is divided into pa Part one focuses on assessment a management of the healthy chi part two addresses assessment a management of common clini problems. The information is p sented in a straightforward man with enough prose to complem extensive outlines covering essen information. In each chapter, authors enhance their pres tations with many tables fr classical texts and articles in pediatric literature, e.g. Tanner a developmental staging.

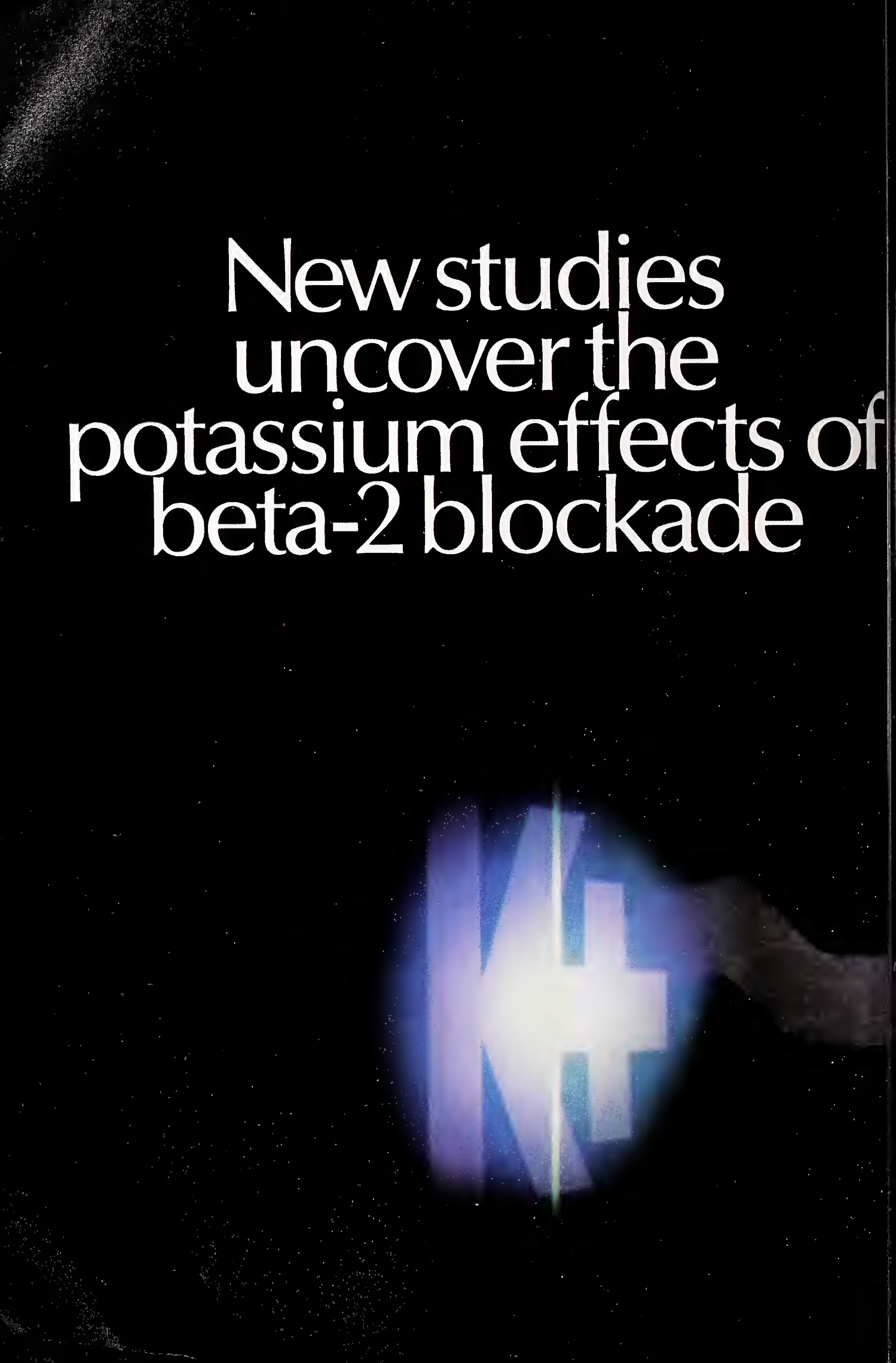
The strength of this text is provide primary health c workers, especially nurses, w ample reference sources, bibli raphies, and charts. Emphasis placed on diagnosis and supp counseling of the child/parent dy The weakness in a book of t nature is the lack of therapeu specifics, which for the most p are mentioned in a general sense. exception is the treatment of u nary tract infections which is rat complete. Being an "updated" s ond edition, some of the bibliog phy is stale by dates. Mention made of Probana and Neomull formulas (now off the market). M tiple pressure TB testing by H test is obsolete. The etiology of pn monia by *Streptococcus pn moniae* and *Diplococcus pn moniae* is redundant.

The book is handsomely boun black with gold lettering and analogous in appearance to a slig ly larger version of our friend, *Merck Manual.*

Frank C. Vanore, M


Evidence
that all beta blockers
are not created equal.

New studies uncover the potassium effects of beta-2 blockade



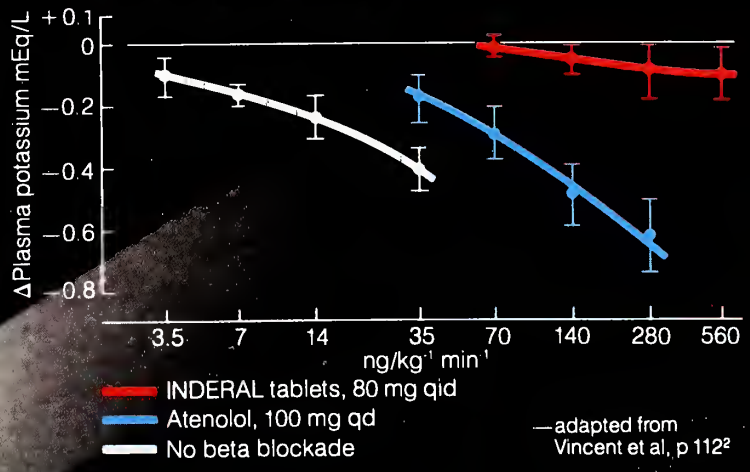
Clinical pharmacology data from the *New England Journal of Medicine:*

"...when normal young men are given infusions of epinephrine at levels such as those that circulate in patients with myocardial infarction, their serum potassium concentrations fall by about 0.8 mmol per liter. Hypokalemia is prevented by...beta-2 blockade."[1]

INDERAL (propranolol HCl) prevented beta-2 mediated hypokalemia

In a pharmacological study comparing INDERAL with atenolol, 10 hypertensive patients were infused with the nonselective beta agonist, isoproterenol, which also stimulates beta-2 mediated hypokalemia. At doses high enough to overcome beta-1 mediated heart rate reductions, the hypokalemia caused by isoproterenol was blunted by INDERAL, but not by atenolol.[2]

INDERAL compared with atenolol: change in plasma potassium after beta-agonist infusion[2]



—adapted from Vincent et al, p 112[2]

For beta-1/beta-2 blockade INDERAL® (PROPRANOLOL HCl) TABLETS

Please see last page for brief summary of prescribing information.

Epinephrine-induced hypokalemia can intensify diuretic-induced hypokalemia



From the *Lancet:*

"Although both diuretics and adrenaline are known to cause hypokalaemia, we believe that this is the first demonstration that these two factors can act in an additive manner. Routine monitoring of serum potassium in patients on thiazide diuretics may underestimate the risks of hypokalaemia."[3]

Epinephrine drives potassium into cells—an effect that has been shown to be under beta-2 receptor control[4]; thiazides promote excretion of potassium. When these actions occur together, hypokalemia can intensify significantly.[3]

Epinephrine-induced hypokalemia can cause ECG abnormalities typical of other forms of hypokalemia

In a study of the effects of epinephrine-induced hypokalemia on the electrocardiogram, it was shown that levels of plasma epinephrine similar to those observed during myocardial infarction can produce changes in ventricular repolarization, which are reflected in T-wave flattening and QT prolongation in normal subjects.[5]

In clinical pharmacology studies of hypertensive and normal patients, epinephrine-induced hypokalemia was prevented by beta-2 blockade.[2,4]

For beta-1/beta-2 blockade

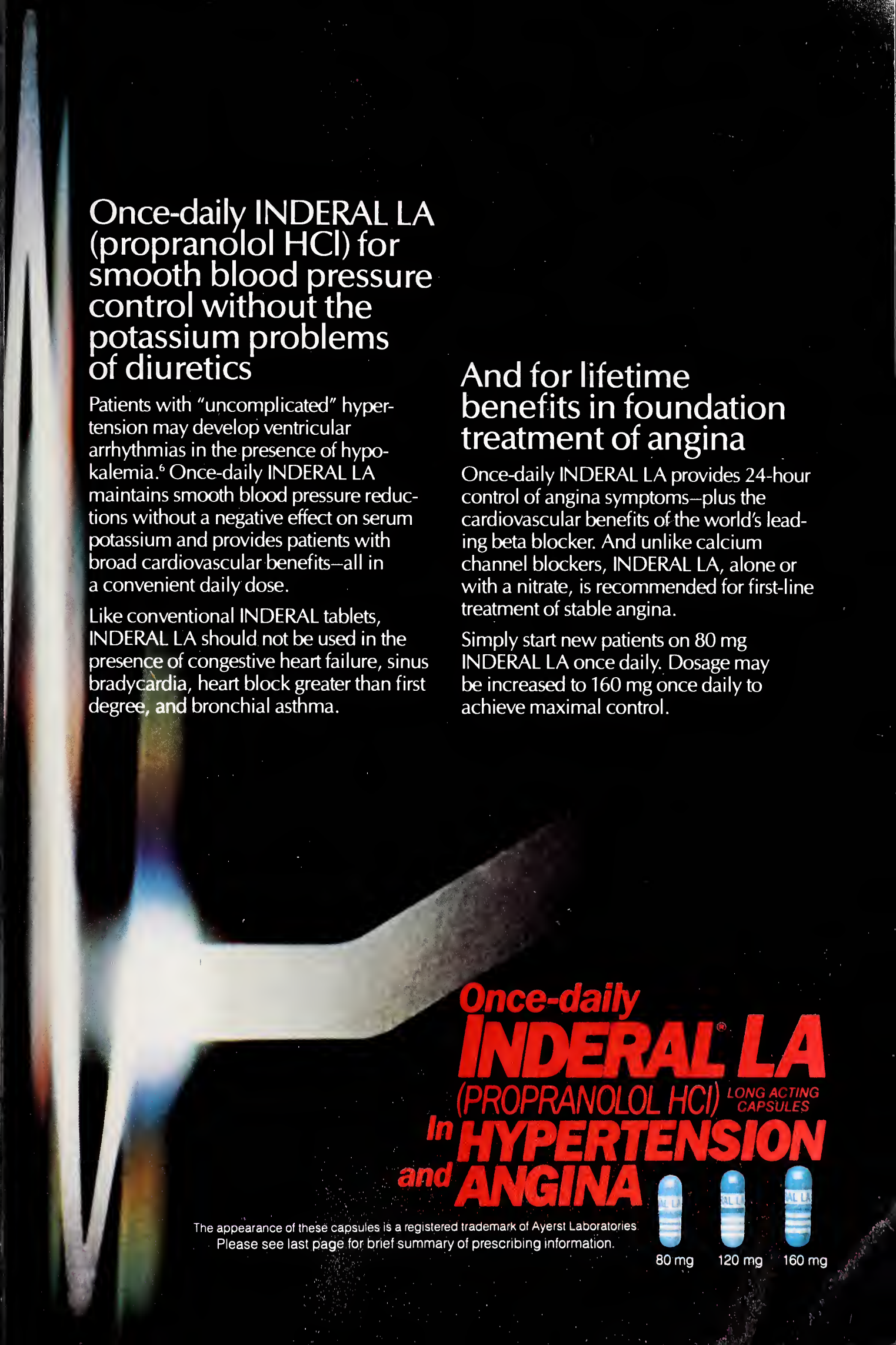
INDERAL®

(PROPRANOLOL HCl) TABLETS

Please see last page for brief summary of prescribing information.

Right from the start in hypertension...





Once-daily INDERAL LA (propranolol HCl) for smooth blood pressure control without the potassium problems of diuretics

Patients with "uncomplicated" hypertension may develop ventricular arrhythmias in the presence of hypokalemia.[6] Once-daily INDERAL LA maintains smooth blood pressure reductions without a negative effect on serum potassium and provides patients with broad cardiovascular benefits—all in a convenient daily dose.

Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

And for lifetime benefits in foundation treatment of angina

Once-daily INDERAL LA provides 24-hour control of angina symptoms—plus the cardiovascular benefits of the world's leading beta blocker. And unlike calcium channel blockers, INDERAL LA, alone or with a nitrate, is recommended for first-line treatment of stable angina.

Simply start new patients on 80 mg INDERAL LA once daily. Dosage may be increased to 160 mg once daily to achieve maximal control.

Once-daily
INDERAL® LA
(PROPRANOLOL HCl) LONG ACTING CAPSULES
In HYPERTENSION and ANGINA

80 mg 120 mg 160 mg

The appearance of these capsules is a registered trademark of Ayerst Laboratories

Please see last page for brief summary of prescribing information.

INDERAL®
(PROPRANOLOL HCl) TABLETS



10 mg 20 mg 40 mg 60 mg 80 mg 90 mg

The appearance of these tablets is a registered trademark of Ayerst Laboratories.

Once daily
INDERAL® LA
(PROPRANOLOL HCl) LONG ACTING CAPSULES



The appearance of these capsules is a registered trademark of Ayerst Laboratories.

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULARS.)*
INDERAL® (propranolol hydrochloride) **Tablets and Injectable**
INDERAL® LA (propranolol hydrochloride) **Long Acting Capsules**

INDICATIONS AND USAGE—INDERAL Tablets

Hypertension: INDERAL (propranolol hydrochloride) is indicated in the management of hypertension. It may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL is indicated for the long-term management of patients with angina pectoris.

Cardiac Arrhythmias:

1.) Supraventricular arrhythmias

a) Paroxysmal atrial tachycardias, particularly those arrhythmias induced by catecholamines or digitalis or associated with the Wolff-Parkinson-White syndrome (See W-P-W under WARNINGS.) b) Persistent sinus tachycardia which is noncompensatory and impairs the well-being of the patient. c) Tachycardias and arrhythmias due to thyrotoxicosis when causing distress or increased hazard and when immediate effect is necessary as adjunctive, short term (2-4 weeks) therapy. May be used with, but not in place of, specific therapy. (See Thyrotoxicosis under WARNINGS.) d) Persistent atrial extrasystoles which impair the well-being of the patient and do not respond to conventional measures. e) Atrial flutter and fibrillation when ventricular rate cannot be controlled by digitalis alone, or when digitalis is contraindicated.

2.) Ventricular tachycardias

Ventricular arrhythmias do not respond to propranolol as predictably as do the supraventricular arrhythmias. a)Ventricular tachycardias. With the exception of those induced by catecholamines or digitalis, INDERAL is not the drug of first choice. In critical situations when cardioversion technics or other drugs are not indicated or are not effective, INDERAL may be considered. If, after consideration of the risks involved, INDERAL is used, it should be given intravenously in low dosage and very slowly. (See DOSAGE AND ADMINISTRATION.) *Care in the administration of* INDERAL *with constant electrocardiographic monitoring is essential as the failing heart requires some sympathetic drive for maintenance of myocardial tone.* b) Persistent premature ventricular extrasystoles which do not respond to conventional measures and impair the well-being of the patient.

3.) Tachyarrhythmias of digitalis intoxication

If digitalis-induced tachyarrhythmias persist following discontinuance of digitalis and correction of electrolyte abnormalities, they are usually reversible with oral INDERAL. Severe bradycardia may occur. (See OVERDOSAGE.) Intravenous propranolol hydrochloride is reserved for life-threatening arrhythmias. Temporary maintenance with oral therapy may be indicated. (See DOSAGE AND ADMINISTRATION in the package circulars.)

4.) Resistant tachyarrhythmias due to excessive catecholamine action during anesthesia

Tachyarrhythmias due to excessive catecholamine action during anesthesia may sometimes arise because of release of endogenous catecholamines or administration of catecholamines. When usual measures fail in such arrhythmias, INDERAL may be given intravenously to abolish them. All general inhalation anesthetics produce some degree of myocardial depression. Therefore, when INDERAL (propranolol hydrochloride) is used to treat arrhythmias during anesthesia, it should be used with extreme caution and constant ECG and central venous pressure monitoring. (See WARNINGS.)

Myocardial Infarction: INDERAL is indicated to reduce cardiovascular mortality in patients who have survived the acute phase of myocardial infarction and are clinically stable.

Migraine: INDERAL is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta receptor stimulation. Clinical improvement may be temporary.

Pheochromocytoma: After primary treatment with an alpha-adrenergic blocking agent has been instituted, INDERAL may be useful as *adjunctive* therapy if the control of tachycardia becomes necessary before or during surgery.

It is hazardous to use INDERAL unless alpha-adrenergic blocking drugs are already in use, since this would predispose to serious blood pressure elevation. Blocking only the peripheral dilator (beta) action of epinephrine leaves its constrictor (alpha) action unopposed.

In the event of hemorrhage or shock, there is a disadvantage in having both beta and alpha blockade since the combination prevents the increase in heart rate and peripheral vasoconstriction needed to maintain blood pressure.

With inoperable or metastatic pheochromocytoma, INDERAL may be useful as an adjunct to the management of symptoms due to excessive beta receptor stimulation.

INDICATIONS AND USAGE—INDERAL LA Long Acting Capsules

Hypertension: INDERAL LA (propranolol hydrochloride) is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL and INDERAL LA are contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital compone supporting circulatory function in patients with congestive heart failure, and its inhibition beta blockade may precipitate more severe failure. Although beta blockers should avoided in overt congestive heart failure, if necessary, they can be used with close follow- in patients with a history of failure who are well compensated and are receiving digitalis a diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta block can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of he failure, the patient should be digitalized and/or treated with diuretics, and the respor observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation o angina and, in some cases, myocardial infarction, following abrupt discontinuance o INDERAL (propranolol hydrochloride) therapy. Therefore, when discontinuance o INDERAL is planned the dosage should be gradually reduced over at least a few weeks and the patient should be cautioned against interruption or cessation of therapy witho the physician's advice. If INDERAL therapy is interrupted and exacerbation of angin occurs, it usually is advisable to reinstitute INDERAL therapy and take other measure appropriate for the management of unstable angina pectoris. Since coronary arter disease may be unrecognized, it may be prudent to follow the above advice in patient considered at risk of having occult atherosclerotic heart disease who are given pro pranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema

PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECE BETA BLOCKERS. INDERAL should be administered with caution since it may block br chodilation produced by endogenous and exogenous catecholamine stimulation of b receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking ther prior to major surgery is controversial. It should be noted, however, that the impaired abilit the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthe and surgical procedures.

INDERAL, like other beta blockers, is a competitive inhibitor of beta-receptor agonists its effects can be reversed by administration of such agents, e.g., dobutamine or proterenol. However, such patients may be subject to protracted severe hypotens Difficulty in starting and maintaining the heartbeat has also been reported with b blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the pearance of certain premonitory signs and symptoms (pulse rate and pressure changes acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be m difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidi Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of sy toms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid fu tion tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have b reported in which, after propranolol, the tachycardia was replaced by a severe bradyca requiring a demand pacemaker. In one case this resulted after an initial dose of 5 propranolol.

PRECAUTIONS. *General:* Propranolol should be used with caution in patients impaired hepatic or renal function. INDERAL is not indicated for the treatment of hyperten emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Pati should be told that INDERAL may interfere with the glaucoma screening test. Withdra may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart dise elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as re pine should be closely observed if INDERAL is administered. The added catecholam blocking action may produce an excessive reduction of resting sympathetic nervous act which may result in hypotension, marked bradycardia, vertigo, syncopal attacks orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals h been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studi both rats and mice, employing doses up to 150 mg/kg/day, there was no evidenc significant drug-induced toxicity. There were no drug-related tumorigenic effects at ar the dosage levels. Reproductive studies in animals did not show any impairment of fer that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxi animal studies at doses about 10 times greater than the maximum recommended hu dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL sh be used during pregnancy only if the potential benefit justifies the potential risk to the fe

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised w INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and h rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; h tension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usual the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by inson lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; vi disturbances; hallucinations; an acute reversible syndrome characterized by disorienta for time and place, short-term memory loss, emotional lability, slightly clouded sensor and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarr constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with ac and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytop purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has b reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male in tence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reac involving the skin, serous membranes and conjunctivae reported for a beta blocker (p tolol) have not been associated with propranolol.

REFERENCES.

1. Epstein FH, Rosa RM. Adrenergic control of serum potassium. *N Engl J* 1983;309:1450-1451. **2.** Vincent HH, Boomsma F, Man in't Veld AJ, et al: Effects of sele and nonselective β-agonists on plasma potassium and norepinephrine. *J Cardiovasc P macol* 1984;6:107-114. **3.** Struthers AD, Whitesmith R, Reid JL: Prior thiazide diuretic t ment increases adrenaline-induced hypokalaemia. *Lancet* 1983;1:1358-1361. **4.** Brown Brown DC, Murphy MB: Hypokalemia from beta$_2$-receptor stimulation by circulating nephrine. *N Engl J Med* 1983;309:1414-1419. **5.** Struthers AD, Reid JL, Whitesmith R, Effect of intravenous adrenaline on electrocardiogram, blood pressure, and serum tassium. *Br Heart J* 1983;49:90-93. **6.** Holland OB, Nixon JV, Kuhnert L: Diuretic-indu ventricular ectopic activity. *Am J Med* 1981;70:762-768.

9410/

Ayerst® AYERST LABORATORIES
New York, N.Y. 10017

Copyright © 1984 AYERST LABORATORIES
Division of AMERICAN HOME PRODUCTS CORPORATION

OBITUARIES

rs. Bernardin; Camejo; arr; Carras; D'Agostin; nkel; Hely; Kratka; acaulay; Mettler; odarelli; Ortolano; Parvin; ollis; and Sandella

Dr. R.M. Bernardin

A pediatrician with offices in Collingswood and Cherry Hill, Ronald Maurice Bernardin, M.D., died at his home on July 19, 1984. Born in Columbia, South Carolina, in 1918, Dr. Bernardin's family moved to Philadelphia. He received his medical degree from Jefferson Medical College in 1944, and immediately entered the United States Army's medical corps for the duration of World War II. A member of our Camden County component and the American Medical Association, Dr. Bernardin was board certified in his specialty. For 20 years he was chief of the pediatrics department at Cooper Hospital/University Medical Center, and also was affiliated with Our Lady of Lourdes Hospital, Camden, and Garden State Hospital, Carlton. Dr. Bernardin was clinical professor of pediatrics at the University of Medicine and Dentistry's Camden campus.

Dr. Rafael Camejo

Word has been received of the death of Rafael Camejo, M.D., on May 8, 1984. Born in 1926 in the Dominican Republic, Dr. Camejo earned his medical degree at the University of Santo Domingo in 1954. He completed his internship at St. Peter's Hospital, New York, in 1956. An anesthesiologist, Dr. Camejo was affiliated with West Hudson Hospital, Kearny; he was a member of our Hudson County component.

Dr. Josephus C. Carr

At the age of 78, Josephus Cornelius Carr, M.D., a member of our Essex County component, died on August 16, 1984. Dr. Carr was a general surgeon who received his medical degree from Harvard University College of Medicine in 1925. His office was located in Newark and Dr. Carr was affiliated with both Doctors Hospital and Beth Israel Medical Center in that same city. Dr. Carr was a member of the American Medical Association, and a Fellow of the American Geriatric Society, of the American Society of Abdominal Surgeons, and of the International Academy of Proctology. In 1975, in recognition of his 50 years as a physician, Dr. Carr was a recipient of MSNJ's Golden Merit Award.

Dr. Peter D. Carras

The former medical director of Christian Health Care Center, Wyckoff, Peter Demosthenes Carras, M.D., died on July 4, 1984. Born in 1918 in Paterson, Dr. Carras earned his medical degree at Hahnemann Medical College and Hospital, Pennsylvania, in 1943. An internist in private practice, Dr. Carras also was affiliated with Paterson General Hospital until 1975; from 1975 to 1983, Dr. Carras was affiliated with the Christian Health Care Center. A member of our Passaic County component and of the American Medical Association, Dr. Carras was a Diplomate of the American Board of Internal Medicine and a Fellow of the American College of Physicians.

Dr. Henry D'Agostin

At the advanced age of 86, Henry D'Agostin, M.D., a gynecologist until his retirement in 1962, died on July 5, 1984. Born in Union City, Dr. D'Agostin obtained his medical degree from New York University School of Medicine in 1923. He had practiced his specialty in Cliffside Park, and had been affiliated with Englewood Hospital for 35 years. He was a Fellow of the American College of Obstetricians and Gynecologists, and a Fellow of the American College of Surgeons. Dr. D'Agostin had been a member of our Bergen County component and of the American Medical Association.

Dr. Jerrold S. Finkel

At the untimely age of 55, Jerrold S. Finkel, M.D., an obstetrician and gynecologist with offices in Edison, died on August 25, 1984. A member of our Middlesex County component, Dr. Finkel was born in Newark, and was a graduate of Hahnemann Medical College and Hospital, Pennsylvania, in 1955. He was a member of the American Medical Association, board certified in his specialty, and a Fellow of the American College of Obstetricians and Gynecologists. He had been an assistant clinical professor at the New Jersey Medical School, Newark, and Rutgers Medical School, Piscataway.

Dr. Charles J. Hely

Charles James Hely, M.D., a physician of Westfield who practiced his specialties in that city for over 30 years, died at his home on August 14, 1984. Born in 1914, Dr. Hely received his medical degree from Hahnemann Medical College and Hospital, Pennsylvania, in 1943. He had been an obstetrician and chairman of that specialty's department at both Muhlenberg and Rahway Hospitals, as well as an assistant clinical professor of obstetrics and gynecology at both the New Jersey Medical School, Newark, and Rutgers Medical School, Piscataway. In more recent years he switched to family practice, and finally practiced occupational medicine, having served till his death from 1975 as medical director for E.I. duPont de Nemours & Company at their facilities in Linden and Newark. Dr. Hely was a member of our Union County component, a member of the American Medical Association, and a Fellow of the American College of Obstetricians and Gynecologists. He had

been active in community affairs: serving as school physician for the Westfield school system for 35 years, medical advisor to the Westfield Rescue Squad, and a member of the advisory council of the Visiting Nurses Association. In 1973 he served a tour of duty with Project Hope on a Navajo reservation in Arizona. During World War II, Dr. Hely served as a battalion surgeon with the U.S. Marine Corps, and was awarded the Bronze Star for bravery in action.

Dr. Harold D. Kratka

Harold David Kratka, M.D., a member of our Morris County component, died on July 5, 1984, at the untimely age of 58. Born in the Bronx, Dr. Kratka received his medical degree from the Faculty of Medicine, University of Geneva, Switzerland in 1956. A pediatrician, he established a practice in Dover and had been the head of the pediatrics department at Dover General Hospital. Dr. Kratka was board certified in his specialty and was a Fellow of the American Academy of Pediatrics.

Dr. Francis A. Macaulay

We just have learned of the death on March 20, 1984, of Francis A. Macaulay, M.D., in Delray Beach, Florida. A member of our Bergen County component, Dr. Macaulay was born in Canada in 1898, and received his medical degree from McGill University Faculty of Medicine, Montreal, Canada, in 1926. An obstetrician, Dr. Macaulay established his practice in Teaneck where he remained until his retirement in 1975. He was a member of the American Medical Association. Dr. Macaulay had been affiliated with Holy Name Hospital, Teaneck, and had served as school physician in that community. In 1976, Dr. Macaulay received MSNJ's Golden Merit Award honoring his 50 years as a physician.

Dr. Fred A. Mettler

A member of our Morris County component, Frederick Albert Mettler, M.D., died on May 22, 1984. Born in 1907 in New York, Dr. Mettler received his medical degree from the University of Georgia Medical School in 1937. A private practicing specialist in neurology and psychiatry, Dr. Mettler was a member of the American Medical Association. Dr. Mettler was active in Medical Society affairs; for ten years he served on the Committee on Medical Defense and Insurance. He also served as chairman of an advisory committee to review health care in New Jersey prisons.

Dr. Walter H. Modarelli

Walter Hector Modarelli, M.D., at the age of 74, died on May 27, 1984. Dr. Modarelli, a retired member of our Hudson County component, was an internist affiliated with St. Mary Hospital, Hoboken, and Pollak Hospital, Jersey City. A Diplomate of the American Board of Internal Medicine, Dr. Modarelli also was a Fellow of the American Academy of Cerebral Palsy and a member of the American Medical Association. Dr. Modarelli received his medical degree from the University of Pennsylvania School of Medicine in 1935.

Dr. James J. Ortolano

A specialist in dermatology and cancer diseases, James Joseph Ortolano, M.D., died on June 23, 1984. Dr. Ortolano, a retired member of our Hudson County component, was born in 1907 and graduated from Georgetown University School of Medicine in 1932. He completed an internship at St. Mary Hospital, Hoboken, and then entered private practice. During his affiliation with St. Mary Hospital, Dr. Ortolano served as president of the hospital medical staff. In 1982, Dr. Ortolano received MSNJ's Golden Merit Award for 50 years of medical service to his community.

Dr. Robert W. Parvin

On August 26, 1984, Robert W. Parvin, M.D., tragically died by drowning in the family swimming pool, at the age of 64. Born in Camden, Dr. Parvin received his medical degree from the Universi of Pennsylvania School of Medicir in 1944. His prime specialty was o thopedic surgery, and he was a filiated with Burlington Coun Memorial Hospital, Mount Holly, a a consultant for that specialty, an also served as their director of med cal education. Dr. Parvin was member of our Burlington Coun component, and also a member the American Medical Associatio He was board certified in orthoped surgery. For more than 30 years D Parvin had served with the Unite States Army's Medical Corps; he ha been chief of orthopedic surgery a the U.S. Military Academy, We Point, New York, and had done tou of duty in Europe, Korea, and mil tary facilities in the United State emerging with the rank of colonel i 1976.

Dr. Nicholas L. Pollis

We just have learned of the deat on June 10, 1984, of Nicholas I Pollis, M.D., a member of our Esse County component. Born in 190 Dr. Pollis received his medica degree from Tufts University Schoo of Medicine in 1928, and prior to hi retirement in the early 1970s, h had practiced family medicine i Newark. He had been affiliated wit St. James Hospital and Sain Michael's Medical Center, Newark Dr. Pollis had been a member of th American Medical Association.

Dr. Joseph F. Sandella

An internist in New Brunswic Joseph Frank Sandella, M.D., die on August 28, 1984. A native of Ne York City, born in 1905, Dr. Sandell was graduated from Bellevue Hosp tal Medical College in 1931. A mem ber of our Middlesex County compo nent, Dr. Sandella was boar certified in his specialty, and a Fe low of the American College of Phy sicians. He had been affiliated wit St. Peter's and Middlesex Genera Hospitals, New Brunswick, and wit Roosevelt Hospital, Metuchen. I 1981, Dr. Sandella received MSNJ Golden Merit Award honoring his 5 years of medical practice.

Style Sheet

The Journal *is the official organ of the Medical Society of New Jersey. The goals of* The Journal *are educational and informational. All material published in* The Journal *is copyrighted by MSNJ.*

CONTENT

The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports based on unusual clinical experiences; review articles; clinical notes, succinct items on some aspect or new observation or technique of a case experience; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update; and an opinion column. Editorials are prepared by the Editor and by guest contributors on timely and relevant subjects; editorials are the responsibility of the author. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the Editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made in New Jersey.

ASSIGNMENT OF COPYRIGHT

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978), a transmittal letter or a separate statment accompanying material offered to *The Journal* of the Medical Society of New Jersey must contain the following language and must be signed by all authors:

"In consideration of *The Journal* of the Medical Society of New Jersey taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *The Journal*, MSNJ."

SPECIFICATIONS

Submit two **manuscripts** that must be typewritten and double-spaced on 8½" by 11" paper. Statistical methods used in articles should be identified. Acknowledgements will be made only for specific preparation of an essential part of the manuscript.

Authors are asked to seek clarity, accuracy, and originality; attention to details of grammar, spelling, and typing are important.

The **title page** should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

The author should submit a 40-word **abstract** to be used at the beginning of the article.

Tables must be typewritten and double-spaced on separate 8½" by 11" sheets, with a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source; written permission for republication from the original publisher must be submitted. The cost of color photographs must be borne by the author.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

The **summary** of the article should not exceed 250 words; it should contain only essential facts.

References should not exceed 35 citations except in review articles, and should be cited consecutively in the text by numbers in parentheses at the end of the sentence. The reference list should be typewritten and double-spaced on separate 8½" by 11" sheets in the numerical order in which they are first cited in the text. The style of reference is that of *Index Medicus:*

1. Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis.* New York, NY, McGraw-Hill, 1969, pp. 42-48.

PUBLICATION POLICY

Receipt of each manuscript will be acknowledged and a copy delivered to the Editor who refers the paper to one or more members of the Editorial Board. The final decision is reserved for the Editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. Galley proofs will be submitted to the author for correction of typographical errors.

REPRINT ORDERS

Reprints may be ordered after the author is notified that the article has been selected for a specific issue of JMSNJ. A check for the cost of reprints including remake charge if order is received after due date must accompany the order.

COMMUNICATIONS

All communications should be sent to the Editor, *The Journal*, MSNJ, 2 Princess Road, Lawrenceville, NJ 08648.

Kirwan Financial Group, Inc.

Financial Planners
for the
Medical Profession

Investments, Pensions, Insurance, Etc.

- **Honest**
- **Sophisticated**
- **Profusely Referenced**

609-778-4388

It's Your Affair, So Don't Lift A Finger

Since we want your
special day to be carefree
just lift the phone and call

Parties Unlimited

Perfect Catering For A Perfect Affair

Trenton, New Jersey
609-890-0778

SUPPOSITORY THERAPY

DESIGNED FOR YOUR SPECIALTY.

VAGINAL	RECTAL	URETHRAL
Progesterone	Hydrocortisone	Nitrofurantoin (Plain & with HC)
Boric Acid	Lidocaine	Hydrocortisone
Ampicillin/ Nystatin	Analgesic	Tetracycline
	Emollient	Lidocaine
	Progesterone (including rectal soln's)	SMZ-TMP

All preparations are available in your choice of potency and are prepared in heat stable bases suitable for shipping via United Parcel Service (UPS) with next day delivery within a 300 mile radius.

Contact us for any special requirements that exist in your practice.

BELVIDERE PHARMACY & SURGICAL

1101 South Avenue
Plainfield, New Jersey 07062 (201) 756-6695

Don't take a chance with your career...



Emergency Physician Associates is seeking physicians with Emergency Medicine, Internal Medicine and Family Practice backgrounds who are experienced and interested in a challenging career in Emergency Medicine.

We are currently interviewing for positions in N.J., Pa., N.Y., De. and Md.

Send your C.V. in confidence to:
James E. George, M.D.
Emergency Physician Associates
P.O. Box 298
Woodbury, N.J. 08096
Or call Susan L. Hughes, Physician Recruitment at (609) 848-3817.

Need A Temporary Physician?

You can take time off while your practice keeps working! Lease CompHealth physicians for your vacations, CME's or for supplementary help.

Want Free Time While You Practice Medicine?

Join CompHealth's Locum Tenens Physician Group.

★

For further information about temporary coverage or locum tenens practice opportunities, call:

412-741-3310

CompHealth

A Physician Group

WILSON ROSS, Regional Administrator
114 Centennial Avenue
Sewickley, PA 15143

PRACTICES FOR SALE

Allergy—
Suburban Philadelphia. Very efficient practice which offers considerable growth potential.

Pediatric—
Central New Jersey. High quality practice in residential area.

Ob/Gyn—
Washington state. Physician is relocating. Must sell.

Rheumatology/I.M.—
Arizona

ENT—
Several large practices in Mid-Atlantic region.

For more information on these and other available private practices, please call:

(215) 667-8630

Health Care Personnel Consulting, Inc.
403 GSB Building
One Belmont Avenue
Bala Cynwyd, Pa. 19004

TAX ADVANTAGED INVESTMENT

Available in Princeton, N.J. technology operation. Already approved by the IRS, total commitment made before the end of the year is deductible as expenses against taxable income.

For more information call Mr. Duncan anytime at 201-842-9247 or leave word anytime at 1-800-824-7888 operator 314.

It's A Major Medical Explosion

The Lakewood, Toms River and Point Pleasant hospitals are all going ahead with major expansion programs... Bricktown opens new facility.

Cross River Professional Center

400 to 2,300 Square Feet

¼ Mile South of Kimball Medical Center

- $12 per square foot
- Graduated rent schedules
- Ownership options available
- Fully landscaped
- Centrally located and 10 minutes to all four major hospitals
- Private entrances and all services available
- Equipment leases available

BARRYMOR ENTERPRISES

Brokers Protected

1200 River Avenue (Route 9), Lakewood, NJ 08701 • (201) 367-2226

Personnel
See Also
Page 1009

CARDIOLOGIST:

Opportunity to practice cardiology with well-established practice conveniently located to a large teaching hospital. Duties include supervising and interpreting Treadmills, Holter monitors, 2D and M-Mode Echocardiography performed in office, patient examinations, hospital rounds and cardiac catheterizations. Abilities to do streptokinase and/or angioplasty desirable. Excellent beginning salary and fringe benefits. Located in Pennsylvania.

Reply with C-V to Box No. 97, JMSNJ Immediate Opening.

Family Practitioner

Excellent opportunity for Board Certified/Eligible Family Practitioner to take over established Hospital-Owned Clinic practice near medium-sized Eastern Pennsylvania city serving a referral population of 35,000.

Contact: Judith Kennedy
1-(800) 441-0996 or (215) 896-5080

MEDICAL PRACTICE SALES AND APPRAISALS

We specialize in the valuation and selling of medical practices. If interested in buying or selling a medical practice, contact our Brokerage Division at:

Health Care Personnel Consulting, Inc.
403 GSB Building
1 Belmont Avenue
Bala Cynwyd, PA 19004
215-667-8630

Plastic Surgeon

Attractive opportunity for Board Eligible or Board Certified Plastic Surgeon to join an established Plastic Surgeon in private practice. Affiliation with three hospitals in medium-sized Pennsylvania city serving a referral population of 1 million.

Contact: Tina Carrigan
1-(800) 441-0996 or (215) 896-5080

CLASSIFIED ADVERTISEMENTS

FAMILY PHYSICIAN—BE with over twenty years practice experience in the metropolitan area. Wishes to relocate to area truly in need of an idealistic and dedicated physician whose only goal is a sense of professional fulfillment true service. Must be in New Jersey. Write Box No. 105, JMSNJ.

FAMILY PRACTICE—Board eligible, ACLS certified, personable, American graduate. Desires office/hospital work in Central/Northern NJ. Please call 201-245-7162 or write to 218 Chestnut St, #A-6, Roselle Park, NJ 07204.

GENERAL SURGEON—Board eligible, wishes to join another surgeon or group in the area of Union County or adjoining counties. If interested contact Dr. Bruno 215-787-2152.

INTERNIST—Will complete residency June, 1985. Ambitious, with excellent bedside manner, desires Southern New Jersey group. If interested, please contact Dr. Krueger at 215-456-7890.

ORTHOPAEDIC SURGEON—American graduate, trained at Downstate Medical Center, NJ. Seeks solo, group or hospital based position. Call 212-819-8706 during business hours or write to Box No. 100, JMSNJ.

PHYSICIAN—Lifetime NJ resident seeks position in pediatric group after completion of postgraduate training. Available July 1985. Please contact Charles Geneslaw, 8372 Loveridge Court, Richmond, VA 23229.

PHYSICAL THERAPIST—NJ registered, available. Seeking cooperative work with physician home/office. Prefers NJ seashore. Write Box No. 106, JMSNJ.

RADIOLOGIST—Board certified in radiology and Nuclear medicine. NJ licensed. Teaching hospital affiliation, desires supervision of Nuclear Medicine with ultrasound & CT. Reply Box No. 107, JMSNJ.

NEEDED—CARDIOLOGIST/INTERNIST—To join busy Cardiology and Internal Medicine practice. Immediate or July '85 availability. Edison, NJ. Reply Box No. 108, JMSNJ.

NEEDED—CARDIOLOGIST/INTERNIST—Cardiologist needed for multi-specialty Internal Medicine group in South Jersey area near Atlantic City. Salary with eventual partnership. Excellent benefit package. If interested please send curriculum vitae to Box No. 102, JMSNJ.

NEEDED—EMERGENCY PHYSICIAN—For new urgent care center in west Morris County. Excellent opportunity. Reply Box No. 104, JMSNJ.

NEEDED—INTERNIST—To join active 3 man pediatric practice. Fully furnished offices with lab and x-ray available. Excellent opportunity. Call 201-584-9390.

NEEDED—PHYSICIANS—New professional office center. Ideal location for all specialties. X-ray and lab available. Many extras. 201-584-9390.

NEEDED—PHYSICIANS—For successful well know walk-in medical office center, Central New Jersey. Full and part time. Skilled and personable, American-trained MDs. Send C.V. to E.V. McGinley, M.D., 1005 N. Washington Avenue, Green Brook, NJ 08812 or call 201-968-8900.

NEEDED—PSYCHIATRIST—Board certified or eligible. Full time position. Full service mental health organization. $49,000 plus extras, full benefits. Scenic Bucks County near Philadelphia. Call Ms. Cifelli 215-822-7510.

FOR SALE—Collins Cardio Pulmonary Lung Analyzer. Modular-Stead Wells Model #0300 with Collins Eagle I Computer and Printer. Interested parties call Monday to Friday 609-883-0500, Ext. 13.

FOR SALE—PRACTICE/HOME/OFFICE—47 year old Family Practice with home and office on large piece of property in attractive Bergen County community. Phone 201-438-8895.

FOR SALE—HOME/OFFICE—Four bedroom colonial with 800 square feet office attached with 4 exam rooms, lab, waiting room. Located in fastest growing area in NJ Marlboro, Manalapan Township. Asking $154,500. Call 201-946-2286.

FOR SALE—PRACTICE—Established Primary Care Practice in Ocean County area. X-ray equipment, EKG and cardiac monitor. Write Box No. 103, JMSNJ.

FOR SALE—South Orange, Prospect Street, corner property. Eight rooms, Suitable for professional use. $129,000 by owner. Please phone 201-762-4558.

OFFICE FOR RENT OR SHARE—New Brunswick-Highland Park area. Furnished, 700 square feet, ample parking, close to the hospital. Rent for $500/month plus utilities or Share for $300/month including utilities. Call 201-846-1661 or 572-7553.

OFFICE SPACE—Available for rent in medical office in Kenilworth, NJ. Write Box No. 109, JMSNJ.

OFFICE SPACE—Union, 2nd floor above internist, busy neighborhood on busline. Excellent location for optometrist, psychiatrist, dentist or surgical subspecialty. Call 201-686-6616 Dr. Worth.

FOR RENT—Professional office in West New York. Corner location with parking space, on Doctor's row. Close to hospital and public transportation. Call 201-278-1000 or 201-947-4333.

RATE INFORMATION FOR MEMBERS: $5.00 per insertion up to 25 words; 10 cents each additional word. Payable in advance. **WORD COUNT:** Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one word, and "Write Box No. 000, c/o JMSNJ" as six words. **COPY DEADLINE:** Fifth of preceding month.

CLIP & SAV

The Medical Society of New Jersey and the Healthcare Information Network

Television Program Guide
September-May

Closed circuit television programs related to issues and concerns of physician members of MSNJ.

- **PRESIDENT'S FORUM:** hosted by Frank Y. Watson, M.D., President, MSNJ
- **THE IMPAIRED PHYSICIAN:** hosted by David I. Canavan, M.D., Director, Impaired Physicians Program, MSNJ
- **STATE OF THE ART:** hosted by Howard D. Slobodien, M.D., Past President, MSNJ

Programs will be featured the first, second, and third Tuesday of each month at 1:00 P.M. There will b an 800 number for viewer participation.

Presented solely through those New Jersey hospitals which are subscribers to the **HIN** closed circu television network. A listing of participating hospitals is on the bottom of this page.

For additional information or comments, contact the Medical Society of New Jersey, Department of Specia Projects, A. Ronald Rouse, Director.

President's Forum

Frank Y. Watson, M.D., President of the Medical Society of New Jersey, will host this program with selected members from the Board of Trustees and appropriate Council and Committee Chairpersons who will present information discussed at the previous Board meetings.

Air time for this program is financed by the Medical Society of New Jersey.

Tuesday, October 2, 1984
Tuesday, November 6, 1984
Tuesday, December 4, 1984
Tuesday, January 1, 1985
Tuesday, February 5, 1985
Tuesday, March 5, 1985
Tuesday, April 2, 1985
Tuesday, May 7, 1985

The Impaired Physician

Air time for this program is financed by the Health Care Insurance Exchange (HCIE) and the Princeton Insurance Company (PIC).

Tuesday, September 11, 1984
"Acute Case of the Impaired Physician"

Tuesday, October 9, 1984
"Rehabilitation Programs"

Tuesday, November 13, 1984
"Aftercare"

Tuesday, December 11, 1984
"The Family and The Disease"

Tuesday, January 8, 1985
"Support Groups"

Tuesday, February 12, 1985
"Problems of Re-Entry"

Tuesday, March 12, 1985
"Followup/Monitoring"

Tuesday, April 9, 1985
"Recidivism/Special Problems"

State of the Art

Air time for this program is finance by the Medical Society of New Jerse

Tuesday, October 16, 1984
Professional Liability
James E. George, M.D., J.D.
and
Mr. Adam Wilczek

Tuesday, November 20, 1984
Continuing Medical Education
Paul Hirsch, M.D.,
Edwin Messey, M.D.
and
Robert Rigolosi, M.D.

Tuesday, December 18, 1984
MSNJ Legislative Activities
Mr. Joseph Katz
and
Mr. Clark Martin

The following programs will be a nounced at a later date:

Tuesday, January 15, 1985
Tuesday, February 19, 1985
Tuesday, March 19, 1985
Tuesday, April 16, 1985
Tuesday, May 21, 1985

Participating Hospitals*: Beth Israel Hospital; Freehold Area Hospital; Memorial General Hospital; Morristown Memorial Hospital; Northern Ocean Hospital System, Inc.; Pascack Valley Hospital; Saint Elizabeth Hospital; Saint Mary's Hospital; Saint Peter's Medical Center; and Underwood-Memorial Hospital.

Hospitals Declaring a Preliminary Interest: Atlantic City Medical Center; ACMC-Mainland Division; Betty Bacharach Rehab. Hospital; Bridgeton Hospital; Carrier Foundation; Clara Maass Medical Center; Community Memorial Hospital; Deborah Heart & Lung Center; Englewood Hospital Association; Hackensack Medical Center; Holy Name Hospital; Hospital Center at Orange; John F. Kennedy Medical Ctr.; KMH/UMC-Stratford Division; Kessler Institute for Rehab.; Monmouth Medical Center; Muhlenberg Hospital; Newark Beth Israel Medical Ctr.; Newton Memorial Hospital; Riverside Hospital; Salem County Memorial Hospital and Saint Clare's Hospital; Saint Francis Medical Center; Warren Hospital; West Hudson Hospital; and West Jersey Hospital-Northern Division.

*Listing of hospitals may have changed since this printing.

CLIP & SAV

THE JOURNAL OF THE MEDICAL SOCIETY OF

NEW JERSEY

DECEMBER 1984



LIBRARY
U.C. SAN FRANCISCO
MAR 15 1985

ECALA

COMPULSIVE GAMBLING

E. & W. BLANKSTEEN
E. & W. BLANKSTEEN AGENCY, INC.

ADMINISTRATORS

THE MEDICAL SOCIETY OF NEW JERSEY

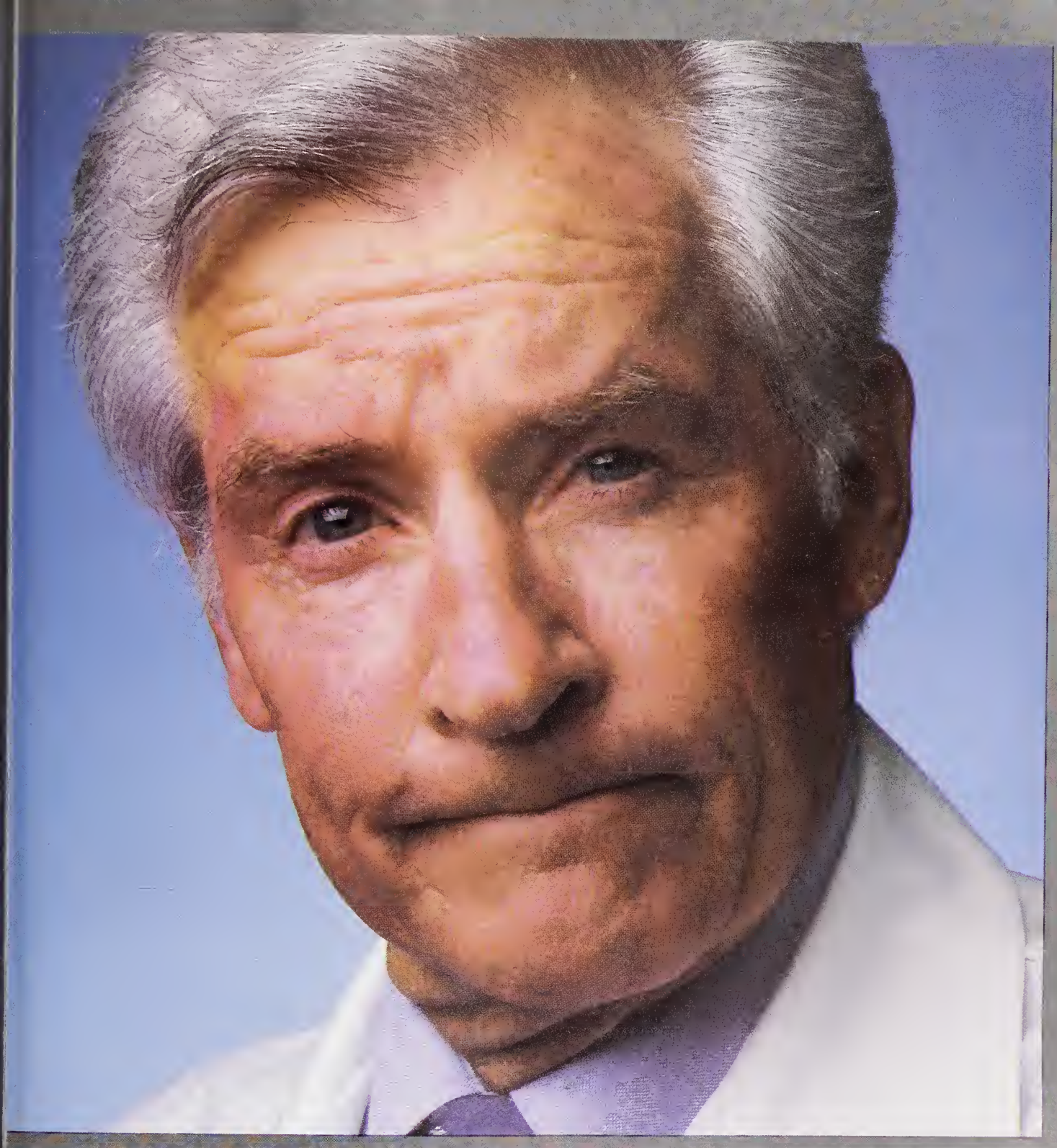
ENDORSED PLANS OF:

LONG-TERM INCOME PROTECTION PLAN
MAJOR MEDICAL
OVERHEAD EXPENSE
HOSPITAL-MONEY
6-POINT HIGH LIMIT ACCIDENT
TERM LIFE
KEOGH

NON-GROUP PROGRAMS OF:

HOMEOWNER'S
OFFICE PACKAGE
LIFE
IRA
PENSION

75 Montgomery Street
Jersey City, N.J. 07201
(201) 333-4340 1-(800) BLANK AG



SO HOW COME YOU'RE STILL WORRIED?

You know they mean well. But you also need to know that many malpractice insurers simply don't have The St. Paul's financial stability. Assets over $5.3 billion. Expertise measured by more than 130 years in the insurance business. Commitment best exemplified by nearly 50 years of providing insurance to the medical community.

More than 55,000 physicians, over 1,550 hospitals and hundreds of thousands of other health care professionals already insure with The St. Paul. They benefit from loss prevention programs that work, claims service that is second to none and the peace of mind that only St. Paul's experienced staff and financial resources can provide.

Call Tim Morse, senior marketing officer in The St. Paul's Medical Services Division. His toll free phone number is 1-800-328-2189, extension 7642. He'll explain our approach and put you in touch with an independent insurance agent who understands your needs.

WORRY-FREE INSURANCE FROM The St Paul

Medical Services Division

PIA

YOUR Insurance Independent AGENT

St. Paul Fire and Marine Insurance Company/St. Paul Mercury Insurance Company/The St. Paul Insurance Company/St. Paul Guardian Insurance Company/The St. Paul Insurance Company of Illinois. Property and Liability Affiliation of The St. Paul Companies Inc., Saint Paul, Minnesota 55102.

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

DECEMBER 198

FEATURES

1021 Membership Newsletter

1033 Physician Legal Bulletin

1037 Professional Liability Commentary

1041 Editorial

1045 Hospital Governing Boards

CONTRIBUTIONS

1046 Compulsive Gambling
Assemblyman Chuck Hardwick, Westfield

1051 New Jersey Combats Compulsive Gambling
R.M. Klein, Trenton

1055 Aortic and Mitral Valve Replacement: Part 2
P. Olivieri, M.D., and J. Kostis, M.D., New Brunswick

1067 Dialysis for End-Stage Renal Disease
J.A. Walker, M.D., R. Dodelson, M.D., R.P. Eisinger, M.D., New Brunswick

1084 Pharmacological Basis of Therapeutics: Dopamine Receptors
R.E. Heikkila, Ph.D., Piscataway

DOCTORS' NOTEBOOK

1088 Trustees' Minutes: October 21, 1984

1088 UMDNJ Notes, *Stanley S. Bergen, Jr., M.D.*

1089 MSNJ Auxiliary, *Grace Gellman*

1089 Current Legislation

1092 Retired Lives Reserve

1093 New Members

1094 Physicians Seeking Location in New Jersey

MSNJ DEPARTMENTS

1096 1984-1985 Liaison Representatives

1099 CME Calendar

1103 Book Reviews

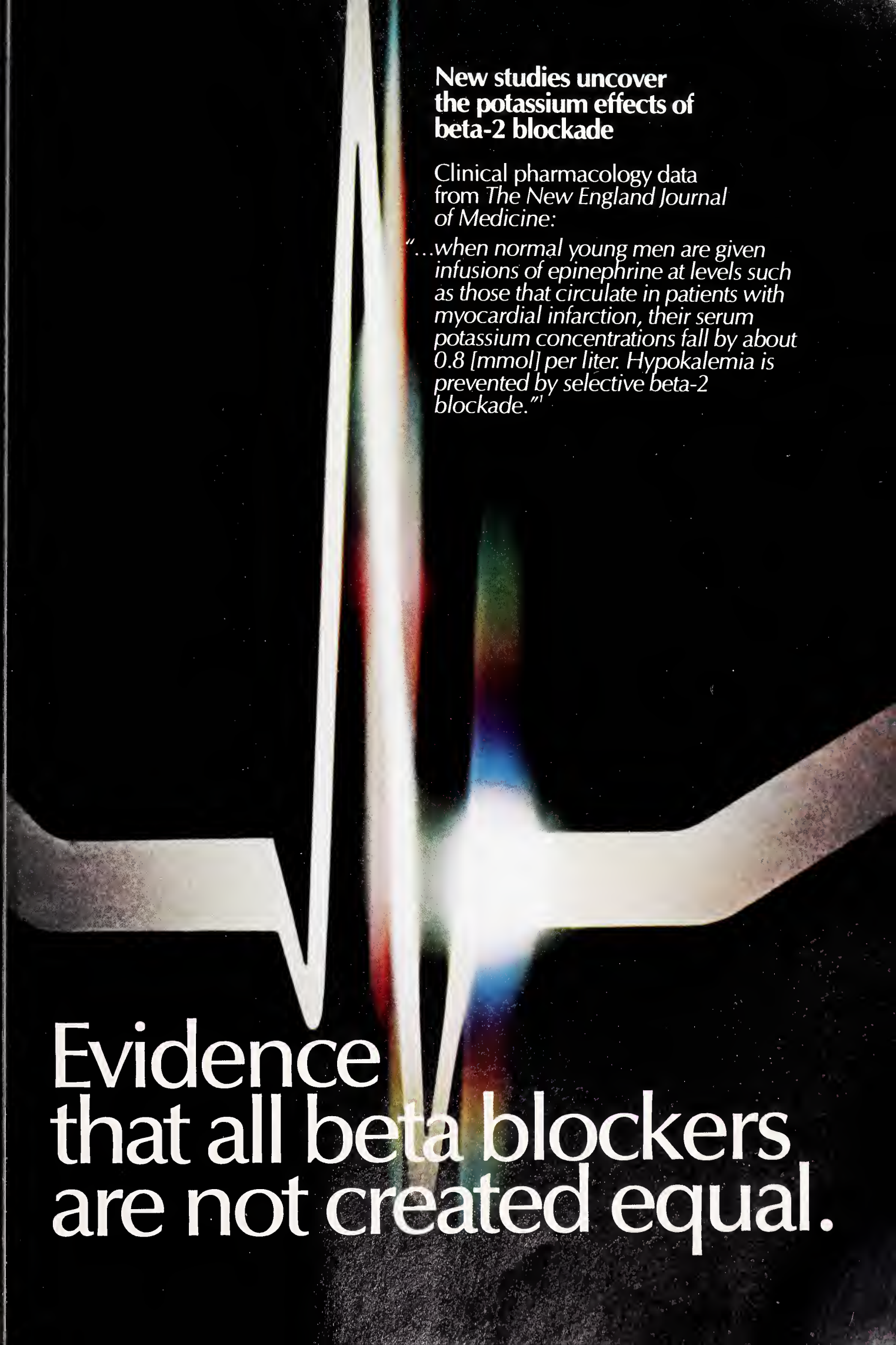
1105 Obituaries

1107 Index: Volume 81

1116 Information for Authors

On The Cover: There is a need for full state involvement to help compulsive gamblers in New Jersey. We feature two articles on the subject, beginning on page 1046. Cover by Frank Cecala.





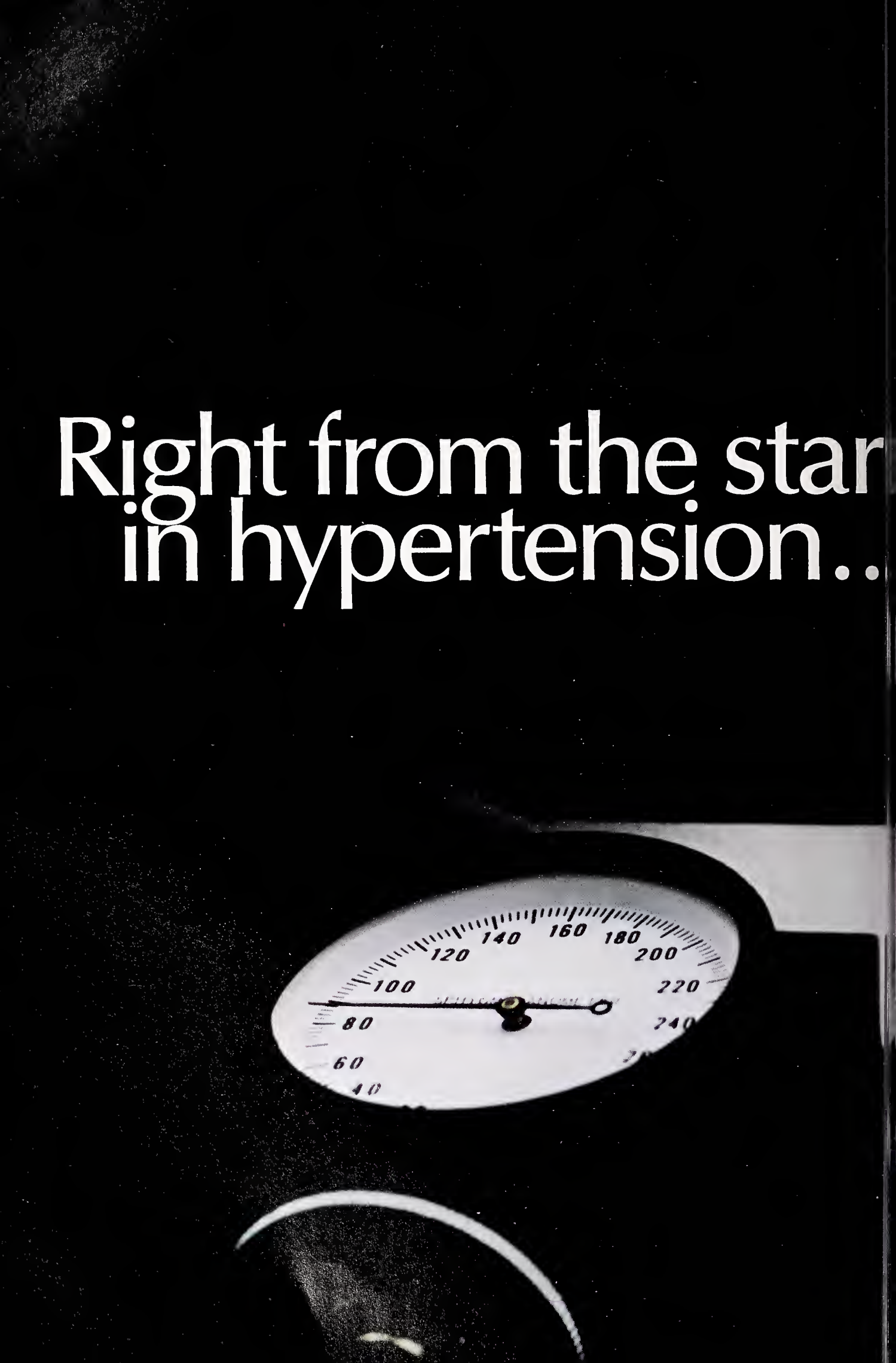
New studies uncover the potassium effects of beta-2 blockade

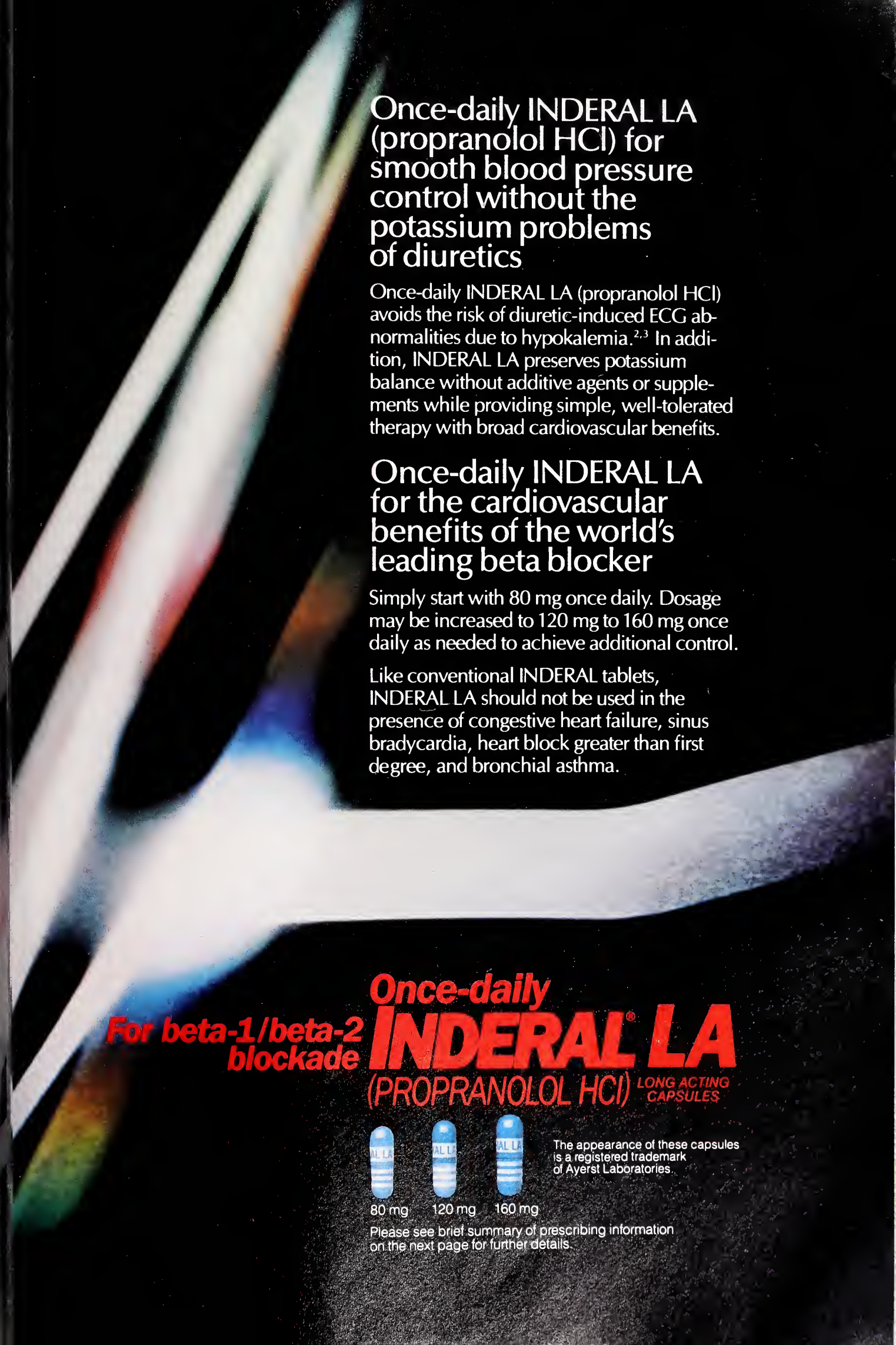
Clinical pharmacology data from *The New England Journal of Medicine:*

"...when normal young men are given infusions of epinephrine at levels such as those that circulate in patients with myocardial infarction, their serum potassium concentrations fall by about 0.8 [mmol] per liter. Hypokalemia is prevented by selective beta-2 blockade."[1]

Evidence that all beta blockers are not created equal.

Right from the star
in hypertension...





Once-daily INDERAL LA (propranolol HCl) for smooth blood pressure control without the potassium problems of diuretics

Once-daily INDERAL LA (propranolol HCl) avoids the risk of diuretic-induced ECG abnormalities due to hypokalemia.[2,3] In addition, INDERAL LA preserves potassium balance without additive agents or supplements while providing simple, well-tolerated therapy with broad cardiovascular benefits.

Once-daily INDERAL LA for the cardiovascular benefits of the world's leading beta blocker

Simply start with 80 mg once daily. Dosage may be increased to 120 mg to 160 mg once daily as needed to achieve additional control.

Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

For beta-1/beta-2 blockade

Once-daily

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES

80 mg 120 mg 160 mg

The appearance of these capsules is a registered trademark of Ayerst Laboratories.

Please see brief summary of prescribing information on the next page for further details.

Once-daily For beta-1/beta-2 blockade INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



The appearance of these capsules is a registered trademark of Ayerst Laboratories.

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta receptor agonists and its effects can be reversed by administration of such agents as dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure change) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dose levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised if INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances, hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with chills and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 240 mg may be required. The time needed for full hypertensive response to a given dose may be variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the validity and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.
PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are limited to permit adequate directions for use.

REFERENCES

1. Epstein FH, Rosa RM. Adrenergic control of serum potassium. *N Engl J Med* 309:1450-1451. **2.** Holland OB, Nixon JV, Kuhnert L: Diuretic-induced ventricular ectopic activity. *Am J Med* 1981;70:762-768. **3.** Holme I, Helgeland A, Hjermann I, et al: Treatment of mild hypertension with diuretics. The importance of ECG abnormalities in the Oslo study and MRFIT. *JAMA* 1984;251:1298-1299.

941

Ayerst® AYERST LABORATORIES
New York, N.Y. 10017

Copyright © 1984 AYERST LABORATORIES
Division of AMERICAN HOME PRODUCTS CORPORATION

MEMBERSHIP NEWSLETTER

MSNJ

HE MEDICAL SOCIETY OF NEW JERSEY VOLUME 17

IE MEDICAL FAMILY

The Impaired Physicians Program, in conjunction th the Auxiliaries of the Medical Society of New Jery and of the New Jersey Association of Osteopathic ysicians and Surgeons, is planning a program on e medical family: its strengths and weakness, and suring its survival. The program will be held on Sunay, March 24, 1985. For further information, please ll, Linda Pleva, at (609) 896-1766.

NIMAL TESTING

The AMA supports the draft, "Principles for the ilization and Care of Vertebrate Animals Used in sting, Research, and Training." The Association ated that adherence to the principles would ensure at laboratory animals are used and cared for properly thout imposing unreasonable restrictions on the e of animals in biochemical research. (Letter of Septmber 20, 1984, to the National Institutes of Health.)

ECIAL JOURNAL ISSUES

The Journal of the Medical Society of New Jersey has printed the William Carlos Williams Commemorative sue (September 1983), a celebration of this New Jery physician and poet.

The September 1984 issue of *The Journal* is a study the history of the healing art in this state. "300 Years Medicine in New Jersey" is a collection of essays tended to dispel erroneous myths about the health ofessionals of New Jersey.

Both issues are available from MSNJ, Two Princess ad, Lawrenceville, NJ 08648, for $5.

REOPERATIVE CHEST X-RAY

The AMA supported the draft report, "Preoperative est Radiology," which concluded that the amount of nically significant information derived from such xys is insufficient to justify ordering them routinely. e Association also stated that it virtually is impossle to set forth a summary list of all appropriate indications for ordering chest x-rays. (Letter of September 20, 1984, to the Food and Drug Administration.)

MALPRACTICE REINSURANCE ASSOCIATION

The legislatively created Malpractice Reinsurance Association which was opposed by MSNJ is in financial difficulty. During the period from 1975 to 1977, MSNJ argued that the proposal was not real insurance, was faulty in design, and was inadequately financed. The Commissioner of Insurance has recognized the existence of the deficit and at a recent meeting with MSNJ and Medical Inter-Insurance Exchange officers he agreed to appoint a Blue Ribbon Committee to advise him on a proper resolution.

The issue simply stated is whether all physicians or only those insured at the time of loss by the Reinsurance Association will be assessed the necessary amounts. MSNJ and MIIENJ have maintained that only physicians insured by the Reinsurance Association are subject to assessment.

Please monitor MSNJ and MIIENJ publications for further information.

PERTUSSIS VACCINE

Pertussis vaccine availability remains tenuous, participants concurred at the Pertussis Strategy Conference sponsored by the American Academy of Pediatrics. Due to a plethora of product liability lawsuits, a number of large U.S. pharmaceutical houses have ceased manufacturing the vaccine. As a result, some physicians are concerned about rising prices and whether the supply of the vaccine will be adequate to meet the need. Lederle Laboratories remains the sole manufacturer in this country. Connaught, a Canadian company, also manufactures the vaccine for U.S. distribution. AAP President Paul Wehrle, M.D., said that the reported cases of pertussis totaled 1,500 to 2,000 per year. Deaths attributable to pertussis range from only 6 to 11 a year. Without vaccine, the incidence of the disease could rise. In foreign countries where immunization rates have dropped, such as Sweden, the

United Kingdom, and Japan, pertussis cases have quickly increased. In the UK, where only 50 percent of the population is immunized, a major epidemic is predicted. If the manufacturers stop making the vaccine, Dr. Wehrle said, the AAP would work with government, industry, the AMA, and other groups to guarantee its continuing availability.

AMBULATORY SURGICAL CENTERS

The Division of Medical Assistance and Health Services has proposed a rule that will appear in the *New Jersey Register*. The rule concerns requirements and reimbursement for Ambulatory Surgical Centers (ASC).

The purpose of an ASC is to provide surgical services to Medicaid patients not requiring hospitalization. The type of surgical procedures covered are those that cannot be performed in a physician's office, but could safely be performed in an ASC.

In order for an ASC to participate as a provider in the New Jersey Medicaid Program, the ASC must be approved by Medicare (Title XVIII), licensed by the New Jersey Department of Health, and have signed an agreement with the Division.

The surgical procedures that may be performed by an ASC are assigned to one of four existing payment groups. Reimbursement is made at the rate that corresponds with the appropriate group.

The physician who performs the surgery can submit the HCFA-1500 claim form and be reimbursed in accordance with Medicaid policies, procedures, and fee schedules.

Please note this is only a summary of the proposal. The text of the proposal provides more detail.

DRIVING UNDER THE INFLUENCE

For the first offense for drunken driving, there is a fine of not less than $250 nor more than $400, and a period of detainment of not less than 12 hours nor more than 48 hours spent during two consecutive days of not less than 6 hours each day and served as prescribed by the program requirements of the Intoxicated Driver Resource Centers. In the discretion of the court, the term of imprisonment will be not more than 30 days and the driver shall forthwith forfeit his right to operate a motor vehicle over the highways of this state for a period of not less than six months nor more than one year.

For a second violation, a person shall be subject to a fine of not less than $500 nor more than $1,000 and shall be ordered by the court to perform community service for a period of 30 days, which shall be of such form and on such terms as the court shall deem appropriate under the circumstances and shall be sentenced to imprisonment for a term of not less than 48 consecutive hours, which shall not be suspended or served on probation, nor more than 90 days, and shall forfeit his right to operate a motor vehicle over the highways of this state for a period of two years upon conviction, and, after the expiration of said period, he may make application to the director of the Division of Motor Vehicles for a license to operate a motor vehicle, which application may be granted at the discretion of the director.

For a third or subsequent violation, a person shall be subject to a fine of $1,000 and shall be sentenc to imprisonment for a term of not less than 180 da except that the court may lower such term for each d not exceeding 90 days, served performing communi service in such form and on such terms as the cou shall deem appropriate under the circumstances ar shall thereafter forfeit his right to operate a mot vehicle over the highways of this state for 10 year

If the driving privilege of any person is under rev cation or suspension for a violation of any provisi of this Title at the time of any conviction for a violati of this section, the revocation or suspension peri imposed shall commence as of the date of terminati of the existing revocation or suspension period. court that imposes a term of imprisonment under th section may sentence the person so convicted to t county jail, to the workhouse of the county wherein t offense was committed, to an inpatient rehabilitati program or to an Intoxicated Driver Resource Cent or other facility approved by the director of t Division of Motor Vehicles and the director of t Division of Alcoholism in the Department of Healt provided that for a third or subsequent offense a pe son shall not serve a term of imprisonment at an Into icated Driver Resource Center.

A person who has been convicted of a previous vi lation of this section need not be charged as a secon or subsequent offender in the complaint made again him in order to render him liable to the punishme imposed by this section on a second or subsequer offender, but if the second offense occurs more tha ten years after the first offense the court shall treat t second conviction as a first offense for sentencin purposes and if a third offense occurs more than te years after the second offense, the court shall treat t third conviction as a second offense for sentencin purposes.

A person convicted under this section must satis the screening, evaluation, referral, and program r quirements of the Division of Motor Vehicles' Burea of Alcohol Countermeasures, and of the Intoxicate Driver Resource Centers. The sentencing court sha inform the person convicted that failure to satisfy suc requirements shall result in a mandatory two-day ter of imprisonment in a county jail and a driver licens revocation or suspension and continuation of rev cation or suspension until such requirements are sa isfied, unless stayed by court order. Upon sentencin the court shall forward to the Bureau of Alcoh Countermeasures a copy of a person's conviction r cord. A fee, not to exceed $40, shall be payable to th Division of Motor Vehicles for the Bureau of Alcoh Countermeasures' screening and evaluation progran

Upon conviction of a violation of this section, th court shall collect the New Jersey driver's license c licenses of the person so convicted and forward suc license or licenses to the director of the Division Motor Vehicles. The person convicted shall be in formed orally and in writing. A person shall be require to acknowledge receipt of that written notice in wri ing.

FINI

"The nicest thing about being imperfect is the jo it brings to others."

ericana
t Farm Resort

HOUSING
APPLICATION

219TH ANNUAL MEETING
MEDICAL SOCIETY OF NEW JERSEY
THURSDAY, MAY 2, TO SUNDAY, MAY 5, 1985

OLLOWING ARE ALL-INCLUSIVE PACKAGE PLANS BASED ON IED AMERICAN PLAN, INCLUDING DINNER AND BREAKFAST STARTING WITH DINNER ON THE DAY OF ARRIVAL, THE SAT- NIGHT BANQUET, LIVE CABARET SHOWS EACH EVENING RING A DIFFERENT SHOW EVERY NIGHT, STATE SALES TAX, LL GRATUITIES COVERING BELLMEN FOR IN/OUT LUGGAGE CE, CHAMBERMAIDS, AND ALL MEAL SERVICE AS OUTLINED:

NIGHT PACKAGE
0 PER PERSON, SINGLE OCCUPANCY
0 PER PERSON, DOUBLE OCCUPANCY
0 PER CHILD SHARING A ROOM WITH PARENTS

E-NIGHT PACKAGE
0 PER PERSON, SINGLE OCCUPANCY
0 PER PERSON, DOUBLE OCCUPANCY
0 PER CHILD SHARING A ROOM WITH PARENTS

NIGHT PACKAGE
0 PER PERSON, SINGLE OCCUPANCY
0 PER PERSON, DOUBLE OCCUPANCY
0 PER CHILD SHARING A ROOM WITH PARENTS

- **Forms received after April 1, 1985, will be confirmed on an "if available" basis.**
- **Fill out only one form for each room required.**
- **DEPOSIT OF $100 PER ROOM MUST ACCOMPANY FORM TO CONFIRM RESERVATIONS.**
- **Please make check payable to HOST FARM. Major credit cards accepted at hotel, but not for deposit.**
- **Hotel confirmation is required for check-in.**
- **Send form and deposit to:**
  Host Reservations
  2300 Lincoln Highway East
  Lancaster, PA 17602
  717-299-5500

K TYPE OF ROOM REQUIRED: ☐ **SINGLE OCCUPANCY** ☐ **DOUBLE OCCUPANCY**
☐ **WILL BE SHARING ROOM****

hotel will not be responsible for assigning roommates. Unless roommate is stated, you will be assigned a single occupancy accommodation.

SE PRINT OR TYPE THE FOLLOWING INFORMATION:

: _____ NO. of CHILDREN: _____

MATES: _____ CHILDREN'S AGES: _____

_____

_____

ESS: _____

_____

E: _____ STATE: _____ ZIP: _____

K IF OFFICIAL DELEGATE ☐ COUNTY: _____

AL DATE _____ DAY _____

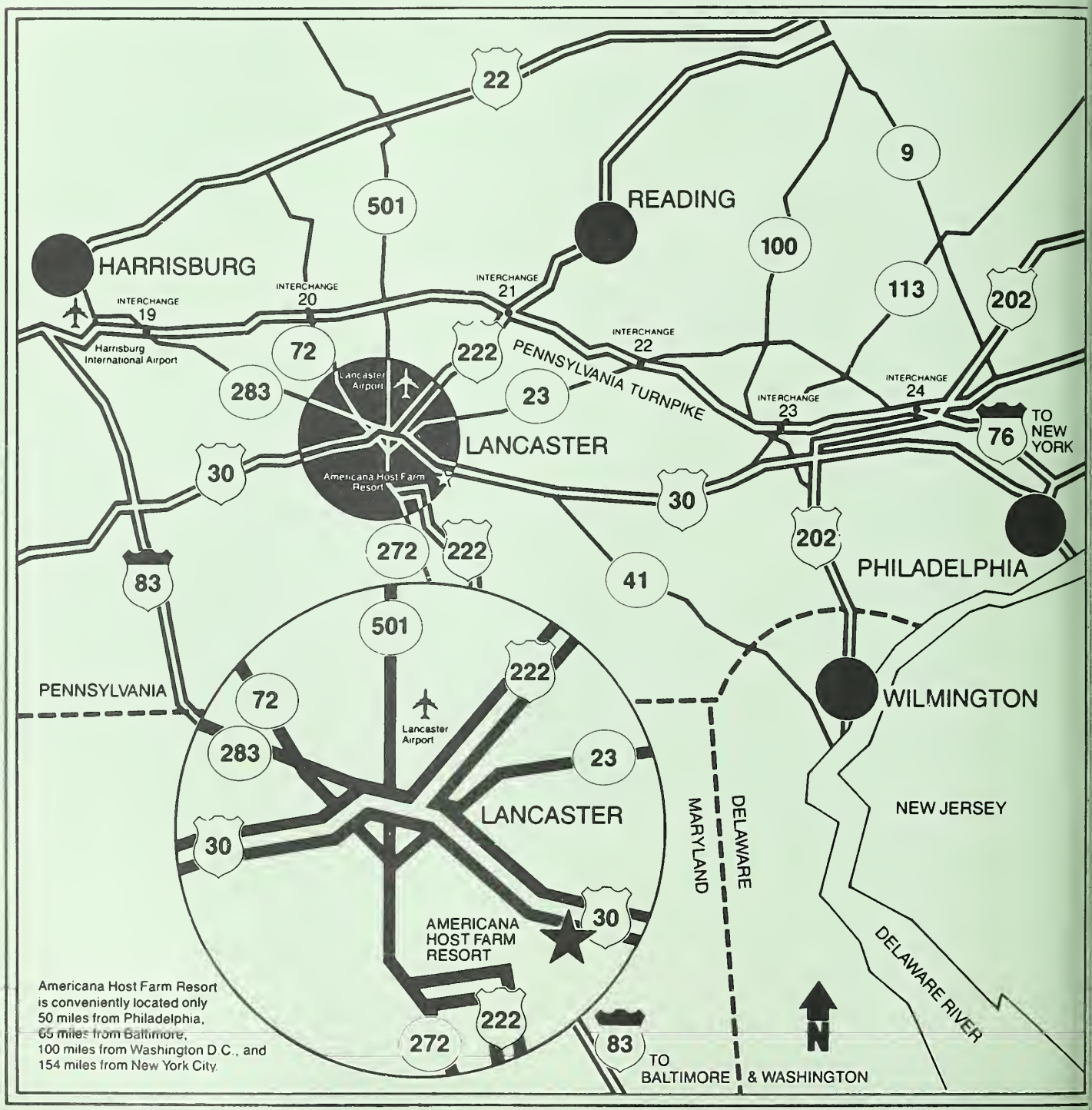
RTURE DATE _____ DAY _____

CHECK-IN: AFTER 4 PM
CHECK-OUT: BY 12 NOON

IEDICAL SOCIETY OF NEW JERSEY—219TH ANNUAL MEETING #2220

Americana
Host Farm Resort

2300 Lincoln Highway East (Route 30), Lancaster, Pennsylvania 17602 (717) 299-5500



FROM NEW YORK
Take New Jersey Turnpike South to Pa. Turnpike. Take Pa Turnpike West to Interchange No. 21. Travel South on U.S. Rte. 222 to U.S. Route 30. Travel East on U.S. Route 30, approximately 5 miles to Americana Host Farm Resort.

FROM PITTSBURGH & POINTS WEST
Travel East on Pa. Turnpike to Int. 19. Go South on I-283 for 30 miles into Route 30 East for 6 miles to Americana Host Farm Resort.

FROM PHILADELPHIA
Take Pa. Turnpike West to Interchange No. 21. Travel South on U.S. Rte. 222 to U.S. Route 30. Travel East on U.S. Route 30, approximately 5 miles to Americana Host Farm Resort.

FROM BALTIMORE & WASHINGTON
Go North on Interstate Route 83 to York, Pa. Turn East on U.S. Route 30 for 32 miles to Americana Host Farm Resort.

BY AIR
Harrisburg International Airport (just 35 minutes from Host by limousine or car) via TWA and U.S. Air, and Lancaster Airport only minutes away with daily flights via U.S. Air.

BY RAILROAD
Amtrak to Lancaster Station. Taxi and Rent-a-Car Service available.

LEGISLATIVE UPDATE

Status of Legislation on Which MSNJ Has Taken an Active Position

Bill	Subject	MSNJ Position	Committee	Present Status
S-70 Codey	To change requirements for eligibility to be Commissioner of Health	Active Opposition	Senate: lHW	In committee
S-111 Bubba	To require a physician to present surgical consent forms at the time surgery is agreed upon	Active Opposition	Senate: LIP	In committee
S-243 Hagedorn	To provide procedures for involuntary civil commitment of the mentally ill	Active Opposition	Senate: lHW	In committee
S-424 Dorsey	To provide for the abolishment of certain state agencies for specific periods of time and to create a Joint Legislative Committee on Regulatory Agencies	Active Support	Senate: SGF&IR&VA	In committee
S-607 Bassano	To require the padding of all metal bars in school buses with energy-absorbing materials to be included in the State Board of Education's rules and regulations	Active Support	Senate: LPS&D	In committee
S-723 Brown	To require the State Department of Health to prepare a booklet on breast cancer and require physicians to give a copy of the booklet to breast cancer patients	Active Opposition	Senate: lHW	In committee
S-752 Hirkala	To provide that certain information of hospitals and long-term health care facility review committees be considered confidential	Active Support	Senate: lHW	In committee
S-754 Hirkala	To provide immunity from civil liability to members of hospital governing bodies in connection with certain review actions taken by them	Active Support	Senate: J	In committee
S-1067 Feldman	To establish and license two categories of social workers	Active Opposition	Senate: lHW	In committee
S-1079 Dumont	Provides for a three-year statute of limitations, except for fraud, intentional concealment, or nontherapeutic or diagnostic purpose. Minors have until age 11 or any injury prior to age 8	Active Support	Senate: J	In committee
S-1112 Hurley	To establish a cap on the amount of damages which may be awarded for pain and suffering in certain civil actions	Active Support	Senate: J	In committee
S-1135 Dalton	To eliminate certain sources of windfall benefits in personal injury and wrongful death actions	Active Support	Senate: J	In committee

LEGISLATIVE UPDATE

Status of Legislation on Which MSNJ Has Taken an Active Position

Bill	Subject	MSNJ Position	Committee	Present Status
S-1140 Feldman	To impose certain requirements on the plaintiff in a medical malpractice proceeding	Active Support	Senate: J	In committee
S-1182 Saxton	To establish the Automobile Insurance Medical Fee Schedule Board	Active Opposition	Senate: LIP	In committee
S-1190 Feldman	To authorize a court to award reasonable attorney's fees to a party who prevails against a frivolous claim for relief in a civil action	Active Support	Senate: J	In committee
S-1714 Bassano	Licenses podiatric x-ray technicians and allows them to take x-rays of the leg* and foot area. Their curriculum and examination will be established and conducted by the Radiologic Technology Board of Examiners (*Note: Current law limits the podiatrist to the "lower leg" and foot.)	Active Opposition	Senate: LIP	Out of committee, amended; 2nd reading
S-1775 Orechio	Allows chiropractors who are licensed to practice by written examination in any state and who have completed 4,300 classroom hours in a chiropractic school to become licensed to practice by virtue of a clinical examination	Active Opposition	Senate: LIP	Out of Assembly; 2nd reading
S-1839 Dalton	Amends existing law to allow a psychologist to supply evidence of a need for guardianship of a minor who is in the custody of the Division of Mental Retardation	Active Opposition	Senate: IHW	In committee
S-1840 Cardinale	Exempts the private practice of medicine from the certificate of need law	Active Support	Senate: IHW	In committee
S-1846 Garibaldi	Provides that cancers caused by exposure to heat, cold, radiation, or a known carcinogen which manifest themselves in active police or firemen are assumed to be accidental and work-related disabilities	Active Opposition	Senate: SGF&IR&VA	In committee
A-115 Otlowski	To authorize optometrists to prescribe a limited number of eye medications	Active Opposition	Assembly: HERP	In committee
A-708 Hardwick	To create a temporary committee to study Diagnosis Related Group System used for setting hospital rates and appropriate $45,000	Active Support	Assembly: CHHS	In committee

LEGISLATIVE UPDATE

Status of Legislation on Which MSNJ Has Taken an Active Position

Bill	Subject	MSNJ Position	Committee	Present Status
A-926 Weidel	To create an Automobile Insurance Fee Schedule Board in the Department of Insurance to adopt a reasonable fee schedule for medical services arising from passenger automobile accidents	Active Opposition	Assembly: BI	In committee
A-960 Miller	To permit individual patients or insurers to appeal hospital bills in cases of assignments under the Diagnosis Related Groups	Active Support	Assembly: CHHS	In committee
A-963 Miller	To eliminate the Diagnosis Related Groups methodology and replace it with one to be devised by the Department of Health in one year	Active Support	Assembly: CHHS	In committee
A-1056 Muziani	To require attending physicians and certified nurse midwives to inform pregnant women of any drugs expected to be used during pregnancy and the possible effects	Active Opposition	Assembly: CHHS	Out of committee; 2nd reading; amended
A-1116 Patero	To permit licensed psychologists to certify disability under Temporary Disability Benefits Law	Active Opposition	Assembly: L	Out of committee; 2nd reading; amended
A-1159 Herman	To require licensed physicians or chiropractors to notify the Board of Medical Examiners if they accept Medicare assignments	Active Opposition	Assembly: HERP	In committee
A-1471 Garvin	To require a physician to obtain, in advance, the patient's authorization to perform a biopsy or mastectomy	Active Opposition	Senate: IHW	Passed in Senate
A-1541 Karcher	To provide for the licensing of persons who practice hypnosis and limit the practice, teaching, or preparation of hypnosis tapes to licensed practitioners	Active Opposition	Assembly: HERP	In committee
A-1559 Garvin	Requires Dept. of Health and the State Board of Medical Examiners to prepare a booklet on all aspects of the treatment of breast cancer. Physicians are required to distribute the book to appropriate patients and to discuss it with them.	Active Opposition	Assembly: CHHS	In committee
A-1682 Muhler	Creates a seven-person Board within the Department of Human Services vested with the authority to release or continue the commitment of persons who were found incapable of standing trial or not guilty by reasons of insanity. A Superior Court judge currently makes these decisions	Active Opposition	Assembly: CHHS	In committee

LEGISLATIVE UPDATE

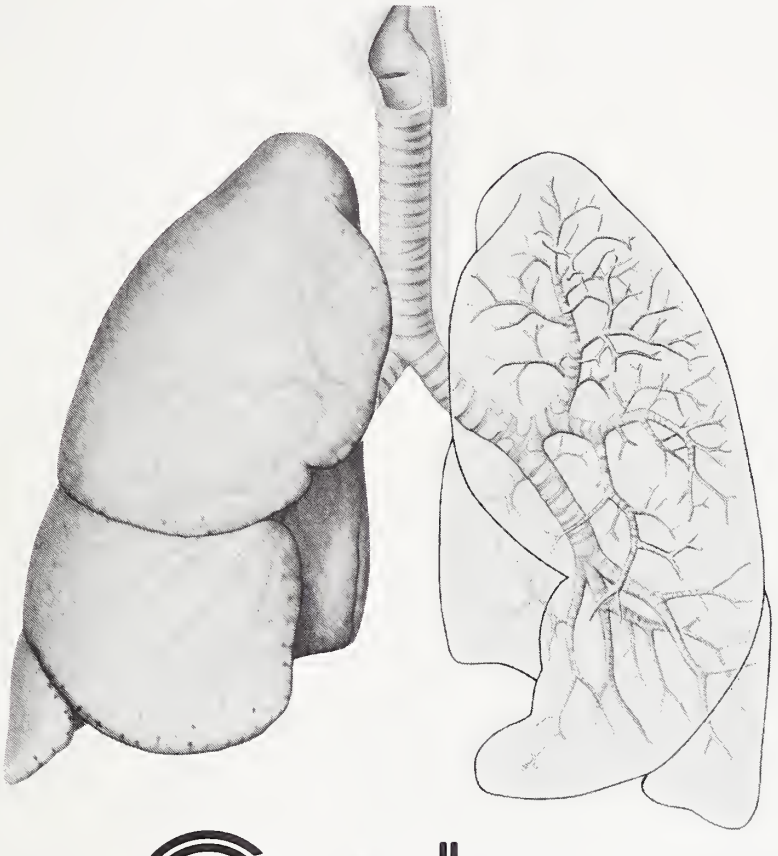
Status of Legislation on Which MSNJ Has Taken an Active Position

Bill	Subject	MSNJ Position	Committee	Present Status
A-1870 Garvin	Amends existing statutes to require either seat belts or restraint systems for all children under ten in a motor vehicle. Current law applies to children under age five	Active Support	Assembly: CI	In committee
A-1921 Miller	Establishes a 3-year statute of limitations in tort actions against health care providers. Children would have until age 11 to bring action for injuries prior to age 8. After age 8, they come under the 3-year standard. Fraud, concealment, and unintentional foreign bodies "toll" the statute	Active Support	Assembly: JUD	In committee
A-1922 Miller	Provides that within 60 days of filing a medical malpractice complaint, the plaintiff must supply an affidavit, by a qualified expert, that reasonable cause exists to believe malpractice occurred	Active Support	Assembly: JUD	In committee
A-2115 Otlowski	Permits optometrists to use topical drugs for treatment and diagnostic purposes	Active Opposition	Assembly: CHHS	Out of committee; 2nd reading
AR-31 Herman	Requests the Commissioner of Health to vigorously educate the public, particularly young people, about the dangers of cigarette smoking	Active Support	Assembly: CHHS	In committee

Senate Committee Key	
IHW:	Institutions, Health and Welfare
J:	Judiciary
LIP:	Labor, Industry and Professions
LPS&D:	Law, Public Safety and Defense
SGF&IR&VA:	State Government, Federal & Interstate Relations & Veterans Affairs

Assembly Committee Key	
BI:	Banking and Insurance
CHHS:	Corrections, Health and Human Services
CI:	Commerce and Industry
HERP:	Higher Education and Regulated Professions
JUD:	Judicial
L:	Labor

Consider the causative organisms...



Ceclor®
cefaclor

250-mg Pulvules® t.i.d.

offers effectiveness against the major causes of bacterial bronchitis

H. influenzae, *H. influenzae*, *S. pneumoniae*, *S. pyogenes*
(ampicillin-susceptible) (ampicillin-resistant)

)f Summary: Consult the package literature for prescribing rmation.

cations and Usage: Ceclor* (cefaclor, Lilly) is indicated in the tment of the following infections when caused by susceptible ms of the designated microorganisms:
ower respiratory infections, including pneumonia caused by *ptococcus pneumoniae (Diplococcus pneumoniae), Haemoph- influenzae*, and *S. pyogenes* (group A beta-hemolytic ptococci)
ppropriate culture and susceptibility studies should be ormed to determine susceptibility of the causative organism eclor.

fraindication: Ceclor is contraindicated in patients with known rgy to the cephalosporin group of antibiotics.

nings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALO- RIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. RE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL OSS-ALLERGENICITY OF THE PENICILLINS AND THE PHALOSPORINS, AND THERE ARE INSTANCES IN WHICH IENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, BOTH DRUG CLASSES.
ntibiotics, including Ceclor, should be administered cautiously ny patient who has demonstrated some form of allergy, icularly to drugs.
'seudomembranous colitis has been reported with virtually all d-spectrum antibiotics (including macrolides, semisynthetic icillins, and cephalosporins); therefore, it is important to sider its diagnosis in patients who develop diarrhea in ociation with the use of antibiotics. Such colitis may range in erity from mild to life-threatening.
reatment with broad-spectrum antibiotics alters the normal a of the colon and may permit overgrowth of clostridia. Studies cate that a toxin produced by *Clostridium difficile* is one nary cause of antibiotic-associated colitis.
Mild cases of pseudomembranous colitis usually respond to discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[0617B2R]

Note: Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

© 1984, ELI LILLY AND COMPANY

Lilly

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Eli Lilly Industries, Inc
Carolina, Puerto Rico 00630



Angina Protection with Benefits for a Lifetime

ONCE-DAILY CONTROL WITH HEART-SAVING BENEFITS

By reducing heart rate and cardiac contractility, INDERAL LA helps protect the heart from the potentially serious and debilitating consequences of ischemia. A highly effective antianginal agent for around-the-clock control of symptoms, INDERAL LA also provides cardiovascular protection for a sense of security in the years ahead.

PROTECTION AND EXPERIENCE NO CALCIUM BLOCKER CAN MATCH

Unlike calcium blockers, INDERAL LA—either alone or with a nitrate—is recommended for early treatment of angina in the majority of patients. Equally important, INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use.

START WITH 80 MG ONCE DAILY

Dosage may be increased to 160 mg once daily, as needed, to achieve optimal control. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY **INDERAL® LA**
(PROPRANOLOL HCl) LONG ACTING CAPSULES



Ayerst®

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

JUST ONCE EACH DAY FOR SIMPLIFIED CORE THERAPY IN ANGINA

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking ther prior to major surgery is controversial. It should be noted, however, that the impaired abilit the heart to respond to reflex adrenergic stimuli may augment the risks of general anesth and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of b receptor agonists and its effects can be reversed by administration of such agents, e dobutamine or isoproterenol. However, such patients may be subject to protracted se hypotension. Difficulty in starting and maintaining the heartbeat has also been reported beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the pearance of certain premonitory signs and symptoms (pulse rate and pressure changes acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be m difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidi Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of sympto of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function te

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have b reported in which, after propranolol, the tachycardia was replaced by a severe bradycar requiring a demand pacemaker. In one case this resulted after an initial dose of 5 propranolol.

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impai hepatic or renal function. INDERAL is not indicated for the treatment of hypertens emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patie should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal n lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disea elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as re pine should be closely observed if INDERAL is administered. The added catecholami blocking action may produce an excessive reduction of resting sympathetic nervous acti which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthost hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals h been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studie both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of signific drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dos levels. Reproductive studies in animals did not show any impairment of fertility that v attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic animal studies at doses about 10 times greater than the maximum recommended human do

There are no adequate and well-controlled studies in pregnant women. INDERAL sho be used during pregnancy only if the potential benefit justifies the potential risk to the fet

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised wh INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and h rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hyp tension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomn lassitude, weakness, fatigue; reversible mental depression progressing to catatonia, vis disturbances; hallucinations; an acute reversible syndrome characterized by disorientation time and place, short-term memory loss, emotional lability, slightly clouded sensorium, a decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrh constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with achi and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytoper purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has be reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male imp tence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactic involving the skin, serous membranes and conjunctivae reported for a beta blocker (practol have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride i sustained-release capsule for administration once daily. If patients are switched from INDER tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeu effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration m be necessary especially to maintain effectiveness at the end of the 24-hour dosing interv

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 r INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may increased to 120 mg once daily or higher until adequate blood-pressure control is achieve The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 6 mg may be required. The time needed for full hypertensive response to a given dosage variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL once daily, dosage should be gradually increased at three to seven day intervals until optim response is obtained. Although individual patients may respond at any dosage level, t average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value a safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few wee (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL once daily. The usual effective dose range is 160-240 mg once daily. The dosage may increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is obtained within four to six weeks after reaching the maximum dose, INDERAL LA thera should be discontinued. It may be advisable to withdraw the drug gradually over a period several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are t limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratorie

8833/3

Ayerst AYERST LABORATORIES
New York, N.Y. 10017

PHYSICIAN LEGAL BULLETIN

THE MEDICAL SOCIETY OF NEW JERSEY

MSNJ

VOLUME 5

THE ALTERNATIVE MEDICAL LIABILITY ACT: PROPOSED SOLUTION TO THE MALPRACTICE PROBLEM

JAMES E. GEORGE, M.D., J.D., AND MADELYN S. QUATTRONE, J.D., LAWRENCEVILLE

Physicians and their professional liability insurers have been proponents of reform in the area medical malpractice litigation. In its present form, edical malpractice litigation is expensive and time nsuming for everyone involved. Over recent years, urts have recognized new causes of action and have warded monetary damages for new categories of inries. In addition, court backlog results in lengthy elays before cases, which have not been resolved out court, finally are adjudicated.

In April 1984, a federal bill, known as HR 5400, was ntended to reform some aspects of medical malpracce litigation, and was introduced in the U.S. House Representatives. The bill has received mixed reviews om those likely to be affected by it.

This essay outlines the salient points of HR 5400 nd presents discussion of its potential impact on hysicians, hospitals, insurers, patients, and atorneys.

According to its sponsors, W. Henson Moore (Republican, Louisiana) and Richard A. Gephardt (Demorat, Missouri), the bill is intended to provide an incenve for hospitals, physicians, and other health care roviders to identify and settle potential cases of nalpractice. (In May, Senator David Durenberger Republican, Missouri], introduced the same legisation in the Senate as S 2690). The bill is intended save insurance dollars by avoiding excessive reoveries while assuring that patients are compensated or losses. The authors of the legislation hope that the neasure indirectly will minimize the need for the pracice of defensive medicine and its resultant increase n the cost of health care.

THE ALTERNATIVE MEDICAL LIABILITY ACT

If enacted, HR 5400, "The Alternative Medical Liability Act," would provide a system for compensating patients in cases of personal injury arising out of patient care provided under federally funded programs (Medicare, Medicaid, CHAMPUS, CHAMPVA, and others). The federal system would allow physicians and other health care providers to avoid the risk of potential lawsuits for medical malpractice by enabling the potentially liable health care providers to make an offer, within a specified period of time, to pay the injured patient's economic losses. The patient to whom an offer is made would lose his right to sue for damages in a court of law.

The offer is a commitment to pay compensation benefits and not a specified amount of dollars. Under the proposed legislation, the injured patient would be entitled to receive compensation for certain economic losses and attorney fees, but could not recover monies for pain and suffering and loss of consortium claims.

The alternative federal system would not apply to cases involving the death of a patient or intentional misconduct by a health care provider. Nor would it apply to any personal injuries occurring before January 1987, or to malpractice cases in those states that have enacted liability systems which conform to the federal alternative system.

The proposed federal system of patient compensa-

*From the Department of Professional Liability Control, MSNJ, where Dr. George is Director and Editor of *PLB* and Ms. Quattrone is Assistant Editor of *PLB*. Correspondence may be addressed to A. Ronald Rouse, MSNJ, Two Princess Road, Lawrenceville, NJ 08648.

tion would be applicable only to cases arising out of medical services rendered under Medicare, Medicaid, the CHAMPUS and CHAMPVA programs, the federal program employees health benefits program, and other federal health programs.

HR 5400 has received mixed reviews from those likely to be affected by it.

TIMELINESS

The bill gives hospitals and doctors a specified period of time to look over their adverse outcome cases to determine which ones are probable liability cases and to identify which cases are likely to lead to litigation. The health care providers are expected to identify the cases for which they will make a compensation offer, or "tender of compensation benefits" as it is termed in the proposed bill.

Physicians and other health care providers must review their cases expeditiously. Tenders must be made to injured patients no later than 180 days after the date of the patient's discharge from the institution where the occurrence took place or, if the patient was not an inpatient, 180 days after the date of the incident giving rise to the injury.

Compensation benefits must be paid no later than 30 days after the date that the claimant has provided reasonable proof of the fact and amount of net economic loss incurred. In the event benefits are not paid on a timely basis, claimants are entitled to interest at the annual rate of interest applied to judgments in the state where the injury occurred.

JOINT LIABILITY

The proposal permits physicians and other health care providers who make an offer of payment to a patient to join as parties other physicians or health care providers. The party who is joined is deemed to have agreed to pay a share of the compensation benefits. Disagreements between the parties with regard to any party's share will be resolved by binding arbitration based on the comparative fault of the providers.

COMPENSATION BENEFITS

The proposed bill restricts the monetary recovery allowable to injured patients. The injured patient will have no right to recover monetary damages for pain and suffering, mental anguish, physical impairment, punitive damages, lost earning capacity, or loss of consortium. A patient to whom a tender is made is limited to recovery for his net economic loss plus attorney's fees. Economic loss includes reasonable expenses incurred for products, services, and accommodations reasonably needed for medical care, training, and remedial treatment, including rehabilitation treatment and occupational training. A patient also may recover for the loss of income from the work he would have performed if he had not been injured. This amount, however, will be reduced by any income from substitute work actually performed by the individ or by income he would have earned in appropri available substitute work which he unreasona failed to undertake. Also, compensable are reasona expenses injured parties incur in obtaining ordin and necessary services they no longer are able to p form.

A significant feature is the requirement that all b efits payable by the provider must be reduced by amount payable by health, accident insurance, wag salary continuation plan, or disability income or surance. Compensation benefits will cease after a fi year period during which no claim for payment made.

If it is determined that a provider has defen against a claim that is fraudulent or without a reas able foundation, the provider will be allowed to reco reasonable attorney's fees. Claimants also are entit to reasonable attorney's fees.

COURT INVOLVEMENT

The federal proposal does not eliminate involvem of the courts. Courts will not have a role in determin liability under the proposal. Rather, courts will hav role in determining the adequacy of settlements a in the discovery of relevant information upon wh the settlement amount is determined. Discov procedures such as depositions and interrogator may be used in accordance with the rules of co Claimants would be obliged to disclose evidence their earnings and to submit to a physical or men examination by a physician. In addition, a claim must furnish reports relating to subsequent treatm and testing in connection with his alleged injuri

Where compensation benefits have been offered a provider and the injured individual disputes amount of compensation owing, the provider or claimant may apply to a court of appropriate juris tion for a declaration as to the amount owed. A compensation benefit exceeding a value of $5,000 net economic loss must have the proposal of a co having jurisdiction of the matter. Court approval required to determine whether the settlement is a quate and fair to the claimant.

Payments may be made to a claimant in a lump s or in periodic payments. Settlement agreements judgments may be modified as to the amounts paya in the future under two circumstances. Payments n be adjusted upon a finding that a material a substantial change of circumstances in the claima condition, loss, or rehabilitation has occurred after date of the agreement or judgment or where r evidence is discovered.

ASSIGNED CLAIMS PLAN

To participate in the federal plan, providers m participate, either directly or indirectly through an surance company, in an assigned claims plan. assigned claims plan may be organized by the st provided it meets federal requirements, or if no st plan exists, the assigned claims plan will be organi federally and maintained. The purpose of an assig claims plan is to provide for assessment of costs a fair basis. If a compensation obliger is financi

nable to pay compensation benefits it owes, the aims will be assigned to a member or members of the an.

OMMENTARY

Is the bill workable and is it fair? These are two uestions invariably raised by health care providers nd their insurers. Attorneys invariably ask, is the bill nstitutional? Is it fair to provide a system of limited covery for patient injuries to one segment of the opulation and a system for more expanded recovery another segment of the population?

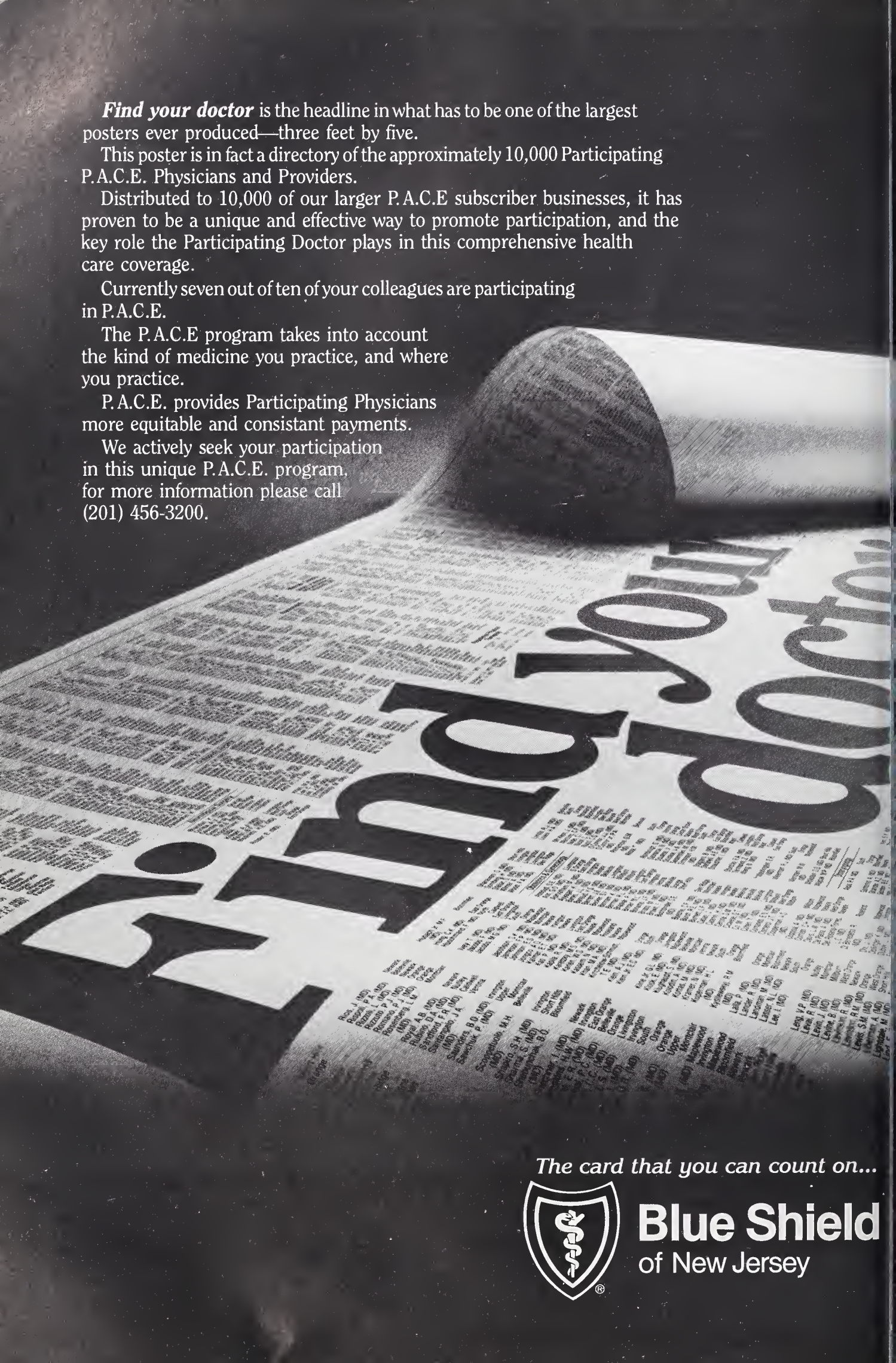
Physicians and their insurers have applauded the ncept of the reduction in compensable categories of amages. The elimination of awards for pain and suf- ring and for loss of consortium and the reduction in enefits by payments made to the patient by his in- urance or other collateral sources clearly are eneficial to the provider.

Other features of the bill have raised some cause for ncern. Will more patients be compensated under the proposed system as compared to the present system so as to offset any benefits to physicians and their insurers? Will the provisions for joining other physicians and providers result in the continued practice of defensive medicine?

Physicians who believe they have provided proper and acceptable care in cases which nonetheless result in a bad outcome may be unwilling to make an offer to pay compensation within the time period provided. Is the short time period fair? Who will be empowered to make a compensation offer, the physician or his insurer? How will the assigned claims plan work?

On balance, it appears that HR 5400 seeks to accomplish many of the objectives sought by physicians and their insurers. The bill deserves careful thought and analysis so that the medical community can assist drafters of the proposal.

There has never been a panacea in the area of medical malpractice. It is doubtful that HR 5400 will fill this role. If HR 5400 is ever passed into law, it still will take many months to know whether the medical malpractice problem is better, worse, or the same.


Find your doctor
Find your doctor is the headline in what has to be one of the largest posters ever produced—three feet by five.
This poster is in fact a directory of the approximately 10,000 Participating P.A.C.E. Physicians and Providers.
Distributed to 10,000 of our larger P.A.C.E subscriber businesses, it has proven to be a unique and effective way to promote participation, and the key role the Participating Doctor plays in this comprehensive health care coverage.
Currently seven out of ten of your colleagues are participating in P.A.C.E.
The P.A.C.E program takes into account the kind of medicine you practice, and where you practice.
P.A.C.E. provides Participating Physicians more equitable and consistant payments.
We actively seek your participation in this unique P.A.C.E. program, for more information please call (201) 456-3200.
The card that you can count on...
Blue Shield
of New Jersey

ROFESSIONAL LIABILITY OMMENTARY*

Malpractice Rates and Awards

orporate Negligence; Can Legislators olve Problems?; Did You Know?; Award o Deaf Child

In the recent Washington State Supreme Court case of Pedroza *v* Bryant, 677 P.2d 166 (1984), Court held that a hospital's duty of care under the trine of corporate negligence extends only to those o are patients within the institution. Under the trine of corporate negligence, a hospital has the ponsibility of supervising the medical treatment vided to hospital patients by members of the medi- staff. Hospital liability for the negligent acts of sicians may arise when it is shown that a hospital s failed to exercise reasonable care in the granting, ewal, or delineation of privileges.

n the Pedroza case, a woman sought treatment at physician's private office when she began to ex- ience problems associated with her pregnancy. The man subsequently was admitted to Skagit Valley spital where the child successfully was delivered by arean section, though the patient did not survive. e doctor who initially misdiagnosed her condition d limited staff privileges at the hospital.

he plaintiff had argued that the hospital should be le for the negligence of the physician because the eased woman had chosen his services as a result his having staff privileges at the hospital and there- e she was a potential patient of the hospital. The rt rejected this argument, holding that: "The hospi- holds itself out to the community as a competent vider of medical care. The hospital does not hold itself out as an inspector or insurer of the private practices of its staff members. The delineation of staff privileges by the hospital can only affect the procedures used by staff members while they are inside hospital walls. The public cannot reasonably expect anything more."

Although the Washington Court did not find liability in this instance, the Pedroza case signifies the continuing trend of this country toward acceptance of the doctrine of corporate negligence in medical malpractice cases, a view which was accepted by a trial court in this state in 1975 [Corleto *v* Shore Memorial Hospital, 138 N.J. Super 302 (Law Div. 1975)] and which is likely to be accepted by the Supreme Court of New Jersey should the issue be raised in that Court. At the same time, the Pedroza case is significant because it limits the doctrine to acts occurring in the hospital.

CAN LEGISLATORS SOLVE YOUR PROBLEMS?

"Stop harping about plaintiffs' lawyers and banging on legislative doors asking for special interest tort reform and instead get your own act together," California Assembly Speaker Willie Brown told the Physician Insurers Association of America.

Brown, who reportedly earned at least $130,000 from his law practice and speeches last year to supplement his $41,000 Assembly income, was described in *Newsweek* (June 11, 1984) as an "ayatollah" who has become the top Democrat in California and one of the most influential blacks in American politics.

The major effect of his June 1 speech at Lake Tahoe was to rankle members in what became a prolonged sparring match between Brown and the audience. Here's a sampling of the pull-no-punches encounter:

Question: "I'm having trouble understanding how a plaintiff's lawyer can justify receiving a $400,000 fee in a million dollar malpractice verdict."

Brown: "You folks have got to stop concentrating on what a plaintiff's lawyer makes. Instances of those large sums are rare. It's like talking about what a doctor charges. Your arguing that point is counterproductive."

Question: "Physicians are practicing defensive medicine to reduce chances of being sued by patients, and isn't that bringing higher medical bills to patients who are your constituents?"

Brown: "That's also a counterproductive argument. When I need treatment, I want you to use every exotic machine, every alternative method to make sure nothing is missed so that I can be healthy forever and ever and ever, without you being motivated by fear of suit."

Question: "Yet here is this plaintiff's lawyer with his huge fee and in my (medical) practice there are limits to what I can charge—limits from Medicare, Medicaid, and state agencies."

Brown: "Again, you are making the wrong argument in the wrong arena. Lawyers' fees are limited, too, in many areas by various agencies when they represent estates or minors or the indigent, and, of course, you are not required to take Medicare patients."

*This item from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse who are, respectively, Director of the Department and Director of Special Projects.

Question: "Would you support a no-fault system to replace the tort system in California?"

Brown: "Yes. Here is an opportunity to abandon selfish roles we play as individual advocates, looking out basically for our own interests but always couching it as if we're looking out for someone else's—the patient's or the victim's. What we have is a social problem—of people being injured and needing compensation—not a crisis generated by one or two big verdicts."

Brown said the entire system for compensating victims could collapse and expressed great concern about social distribution that could occur as a result. "If you are prepared to discuss contingency fees of lawyers at the same table and in the same room where your professional fees are discussed, I would agree to that. The public, of course, would like to see us in that kind of a contest because they think we all charge too much." (*Medical Liability Monitor*, Vol. 9, No. 7, July 25, 1984)

DID YOU KNOW . . .

A California disciplinary board could be prevented from discouraging treatment it considers unsafe? The Jehovah's Witnesses have won the right to sue the state for violating their religious freedom by discouraging doctors from performing "bloodless" surgery. That, the Witnesses say, infringes on their First Amendment rights, since group members refuse blood transfusions as a matter of religious belief. (*Medical Economics*, May 28, 1984)

As the role of professional review organizations changes under Medicare's prospective-payment system, physicians will become more vulnerable to liability claims, PRO directors warn? For example, if a review board determines that a physician performed unnecessary surgery, the Medicare patient will be notified. The result could be a malpractice suit against the doctor. PROs recommend that doctors take this precaution: Get your review board's approval of the procedure before surgery. (*Medical Economics*, July 9, 1984)

Medical liability rates increased last year as the frequency and severity of malpractice claims continued to rise, according to the American Medical Assurance Co.? The average loss by settlement or judgment rose approximately 20 percent. As a result, 22 physician-owned companies raised premiums ranging from 6 to 30 percent, adding at least $60 million to the overall cost of medical liability insurance. In 1984, at least 14 physician companies already have increased rates again. The increases range from 6 to 39 percent. Others will increase premiums before the end of the year. (*AMA Newsletter*, Vol. 16, No. 19, May 22, 1984)

AWARD TO DEAF CHILD

The state was liable for $1,500,000 for medical malpractice for the negligent evaluation and treatment of a deaf child at a state school, a New York appellate court ruled.

The patient was born prematurely on August 20, 1962, to a mother who had a family history of epilepsy. After repeated hospitalizations, he was institutionalized. His medical records indicated that his hearing was questionable. A Kuhlmann I.Q. test was administered and he recorded a score of 24. On the basis of that test score, he was considered not suitable for a trainable and educable program.

In May 1967, he was enrolled in a speech class. His teacher labeled him as a "very bright" child who could "learn quickly." In August 1967, he was described as an interested youngster who was extrememly alert but deaf. Despite those observations inconsistent with his recorded I.Q. of 24, he was not re-evaluated intellectually until June 1971. In November 1976, a claim was brought against the state of New York by the patient both individually and by his parent and natural guardian, to recover damages emanating from the patient's admission and confinement at one state school from June 1965 to August 1972, and at another state school from August 1972 to December 31, 1974. A trial court found that the state committed medical malpractice and awarded the patient $2,500,000 as compensation for the lost years of proper training.

Reducing the award to $1,500,000, the appellate court said the trial court's award was an exorbitant amount reflecting the court's sympathy. The court accurately determined that the state's action was medical malpractice, rather than educational malpractice for which there was no action. Failure to conduct a re-evaluation of the patient's classification as an imbecile with any degree of diligence departed from accepted medical standards and was malpractice, the court said—Snow *v* State of New York, 469 N.Y.S.2d 959 (N.Y. Sup. Ct., App. Div., Dec. 27, 1983). (*The Citation*, Vol. 49, No. 6, July 1, 1984)

Motrin reduces inflammation, pain ...and price

New low price...major savings

The dramatic reduction in the price of *Motrin* Tablets means substantial savings from now on for your patients and for patients all across the country for whom *Motrin* Tablets are prescribed.

Motrin is priced lower than Clinoril, Feldene, or Naprosyn.

The price of *Motrin* Tablets to pharmacies has been reduced as much as 35%. Patients taking the average dosage should now pay less for therapy with *Motrin* Tablets than for almost any other nonsteroidal anti-inflammatory drug you prescribe...less, for example, than for Clinoril, Feldene, or Naprosyn. And, of course, all strengths of *Motrin* Tablets continue to be available by prescription only.

Please see the following page for a brief summary of prescribing information.

Motrin® 400 & 600 mg TABLETS
ibuprofen

Good medicine...good value

© 1984 The Upjohn Company

The Upjohn Company Upjohn Kalamazoo, Michigan 49001

Motrin® Tablets (ibuprofen)

Contraindications: Anaphylactoid reactions have occurred in individuals hypersensitive to *Motrin* Tablets or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin, iodides, or other nonsteroidal anti-inflammatory agents.

Warnings: Peptic ulceration and GI bleeding, sometimes severe, have been reported. Ulceration, perforation and bleeding may end fatally. An association has not been established. Use *Motrin* Tablets under close supervision in patients with a history of upper gastrointestinal tract disease, after consulting ADVERSE REACTIONS. In patients with active peptic ulcer and active rheumatoid arthritis, try nonulcerogenic drugs, such as gold. If *Motrin* Tablets are used, observe the patient closely for signs of ulcer perforation or GI bleeding.

Chronic studies in rats and monkeys have shown mild renal toxicity with papillary edema and necrosis. Renal papillary necrosis has rarely been shown in humans treated with *Motrin* Tablets.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue *Motrin* Tablets and the patient should have an ophthalmologic examination, including central visual fields and color vision testing.

Fluid retention and edema have been associated with *Motrin* Tablets; use with caution in patients with a history of cardiac decompensation or hypertension. In patients with renal impairment, reduced dosage may be necessary. Prospective studies of *Motrin* Tablets safety in patients with chronic renal failure have not been done.

Motrin Tablets can inhibit **platelet aggregation** and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and on anticoagulant therapy.

Patients should report signs or symptoms of **gastrointestinal ulceration** or bleeding, skin rash, weight gain, or edema.

Patients on prolonged **corticosteroid therapy** should have therapy tapered slowly when *Motrin* Tablets are added.

The antipyretic, anti-inflammatory activity of *Motrin* Tablets may mask inflammation and fever.

As with other nonsteroidal anti-inflammatory drugs, borderline elevations of liver tests may occur in up to 15% of patients. These abnormalities may progress, may remain essentially unchanged, or may be transient with continued therapy. Meaningful elevations of SGPT or SGOT (AST) occurred in controlled clinical trials in less than 1% of patients. Severe hepatic reactions, including jaundice and cases of fatal hepatitis, have been reported with ibuprofen as with other nonsteroidal anti-inflammatory drugs. If liver disease develops or if systemic manifestations occur (e.g. eosinophilia, rash, etc.), *Motrin* should be discontinued.

Drug interactions. *Aspirin:* used concomitantly may decrease *Motrin* blood levels.

Coumarin: bleeding has been reported in patients taking *Motrin* and coumarin.

Pregnancy and nursing mothers: *Motrin* should not be taken during pregnancy or by nursing mothers.

Adverse Reactions: The most frequent type of adverse reaction occurring with *Motrin* is gastrointestinal of which one or more occurred in 4% to 16% of the patients.

Incidence Greater than 1% (but less than 3%)—Probable Causal Relationship

Gastrointestinal: Nausea;* epigastric pain;* heartburn;* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence); **Central Nervous System:** Dizziness;* headache, nervousness; **Dermatologic:** Rash* (including maculopapular type), pruritus; **Special Senses:** Tinnitus; **Metabolic/Endocrine:** Decreased appetite; **Cardiovascular:** Edema, fluid retention (generally responds promptly to drug discontinuation; see PRECAUTIONS).

Incidence less than 1%—Probable Causal Relationship**

Gastrointestinal: Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, melena, gastritis, hepatitis, jaundice, abnormal liver function tests; **Central Nervous System:** Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma; **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia; **Special Senses:** Hearing loss, amblyopia (blurred and/or diminished vision, scotomata, and/or changes in color vision) (see PRECAUTIONS); **Hematologic:** Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit; **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations; **Allergic:** Syndrome of abdominal pain, fever, chills, nausea and vomiting; anaphylaxis; bronchospasm (see CONTRAINDICATIONS); **Renal:** Acute renal failure in patients with pre-existing significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria; **Miscellaneous:** Dry eyes and mouth, gingival ulcer, rhinitis.

Incidence less than 1%—Causal Relationship Unknown**

Gastrointestinal: Pancreatitis; **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri; **Dermatologic:** Toxic epidermal necrolysis, photoallergic skin reactions; **Special Senses:** Conjunctivitis, diplopia, optic neuritis; **Hematologic:** Bleeding episodes (e.g., epistaxis, menorrhagia); **Metabolic/Endocrine:** Gynecomastia, hypoglycemic reaction; **Cardiovascular:** Arrhythmias (sinus tachycardia, sinus bradycardia); **Allergic:** Serum sickness, lupus erythematosus syndrome, Henoch-Schonlein vasculitis; **Renal:** Renal papillary necrosis.

*Reactions occurring in 3% to 9% of patients treated with *Motrin*. (Those reactions occurring in less than 3% of the patients are unmarked.)

**Reactions are classified under *"Probable Causal Relationship (PCR)"* if there has been one positive rechallenge or if three or more cases occur which might be causally related. Reactions are classified under *"Causal Relationship Unknown"* if seven or more events have been reported but the criteria for PCR have not been met.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis. Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Do not exceed 2400 mg per day. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary.

Caution: Federal law prohibits dispensing without prescription. MED B-7-S

Motrin is a registered trademark of The Upjohn Manufacturing Company.

Upjohn The Upjohn Company
Kalamazoo, Michigan 49001

Helping Medical Management Manage

Sixteen years ago, Mary Ann Hamburger of Maplewood took a job for a doctor managing his office. Today, as a medical management consultant, Mary Ann Hamburger Assoc.'s responsibilities include making sure everything runs smoothly for the physician and his or her staff.

Part of her job is to make certain that the current billing system is working efficiently, to update the filing system, to clear up any booking problems as far as appointments are concerned and any problems relating to the management or business side of a medical practice.

Mary Ann Hamburger Assoc. will benefit any doctor in an existing practice having a problem with the business aspect of his or her practice and all new doctors who plan to set up practice in the near future. Her service can also include the hiring aspect of doctors' offices, if desired.

Further information on medical management is available from Mary Ann at

201-763-7394

TAX SHELTERS

Just one of the personal financial services available to you from the ***physician's bank.***

- tax planning
- lines of credit
- equipment financing
- retirement planning

- money management
- cash flow • investments
- estate planning

Call or Write

Joseph J. Verbaro, Jr.
Senior Vice President
(201) 228-9770

FINTRUST
FINANCIAL AND TRUST SERVICES

DIVISION OF SECURITY NATIONAL BANK & TRUST COMPANY OF NEW JERSEY

101 Eisenhower Parkway
Roseland, New Jersey 07068 Member F.D.I.C.

Is There a Doctor in the House?

FRANK J. PRIMICH, M.D.

The cost crisis in health care has created a variety of problems. And something must be done. Can physicians help solve some of these problems?

Traditionally, when problems arose regarding illness or injury, the first opinion sought was that of a physician. Currently, the "cost crisis" in health care has spawned a plethora of instant experts. They range from politicians to Ph.Ds. The few token MDs consulted either are far removed from direct patient care or are obligated to present a cooperative position to make the best of a bad situation.

Lawyers and consumer advocates have had a field day exploiting the side effects of medications and operative procedures. Since there is nothing in life which is risk-free, cost-free, or free of responsibility, every decision must reflect the risk-benefit ratio involved. When one considers alternatives in treatment, including no treatment, the factors of risk, cost, and effort must be balanced against the benefit to be derived. The concept of informed consent assumes awareness of predictable risks and costs, and reasonable expectations regarding results. Ideally, such decisions are best made by the patient and the physician. Intry of a third party, be it government or private surer, injects a different set of value judgments.

The Utopian vision of high-quality health care for all Americans is a desirable, though actuarially impossible, goal. The irresponsible political promise of such levels of care sowed the seeds of our dilemma. Entrapment by government has drawn harsh criticism in the Abscam and DeLorean cases, wherein individuals succumbed to the lure of illegal profit. In health care, the entrapment consisted of encouraging "legal" expenditures on overexpansion, overutilization, and marginally beneficial technological advances. While there undoubtedly were some who improperly, illegally, or immorally exploited the system, the vast majority simply abided by the rules and guidelines of the era.

Excessive costs eventually became apparent. Misdirecting the blame was a political imperative. Such misdiagnosis precludes any adequate cure.

The crisis atmosphere associated with the impending bankruptcy of Social Security dominated domestic concerns through prolonged bipartisan negotiations of a "solution." Medicare's instability of similar proportions was "resolved" as an afterthought. Changes were introduced with no substantive evidence of supposed benefits, nor consideration of predictable damages.

Diagnosis Related Groups (DRGs) originated as a method of cost analysis. Conversion to a reimbursement methodology was fraught with potential hazards. DRGs best are described as an illogical, impersonal, and often inhumane system directed almost exclusively to cost containment, with an inevitable negative impact upon quality and availability of health care. Incremental introduction is akin to the "frog in boiling water" analogy. The gradual change is met by accommodation until it is too late to escape the end result.

New Jersey's federally sponsored "experiment" with DRGs began in 1980. MSNJ's concerns were allayed by the promise that the program would be limited and voluntary. When it was arbitrarily expanded to a mandatory all-inclusive system, objections and warnings from practicing physicians fell on deaf ears. My testimony before government committees was disregarded. It was announced that "something had to be done," and any untoward side effects would be addressed when they occurred.

The prime impetus to passage of the regulations was the unsubstantiated claim of success by the New Jersey State Department of Health. To this day, there has been no appreciable evidence to support that claim. It was ironic that the federal Health Care Financing Administration now has refused to extend the New Jersey waiver because of "excessive cost increases." Actually, the charge is inaccurate. It evolved from one of the many apple and orange comparisons that our reliance on computerized statistics fosters. The figures are compiled, at great expense, using different units of measurement which ensure the favorable or unfavorable bottom line being sought. The academicians have little comprehension of the human values involved. The appalling inaccuracy of their projections deserves further condemnation.

Arbitrary determination of the appropriate percentage of GNP to be allotted to health care is presumptuous. Most individuals gladly would expend more than 10.5 percent of their gross product to maintain or regain their health. Billions are spent on fads and quackery. When a problem is vital and personal, cost considerations become secondary. Assuming the citizenry to be incompetent of exercising free choice and individual responsibility regarding health care portends confiscation of our other liberties. Decisions made by dictate or lottery will shatter forever our treasured illusion of self-determination.

Meanwhile, enslavement of physicians under socialized medicine will deter the entry of students into the study and practice of medicine. Computers may fill the void for a while, but the day will come when the urgent cry, "Is there a doctor in the house?" will be answered by an eerie silence.

Just once each day...

First-step blood pressure control with optimal simplicity

Benefits diuretics cannot offer... Once-daily INDERAL LA (propranolol hydrochloride) with its smooth 24-hour control of blood pressure provides a high degree of patient acceptance without potassium problems, plus the cardiovascular benefits of the world's leading beta blocker.

Experience no other beta blocker can match... Once-daily INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.



Start with 80 mg once daily... Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



80 mg 120 mg 160 mg

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

Just once each day for initial therapy in hypertension.

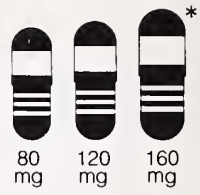
Ayerst

Just once each day for initial therapy in HYPERTENSION.

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.
INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.
INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.
The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.
In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.
In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.
The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the platelets of the brain.
Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.
Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.
Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.
Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.
Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.
IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.
MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking th prior to major surgery is controversial. It should be noted, however, that the impaired ab the heart to respond to reflex adrenergic stimuli may augment the risks of general anest and surgical procedures.
INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of receptor agonists and its effects can be reversed by administration of such agents, dobutamine or isoproterenol. However, such patients may be subject to protracted s hypotension. Difficulty in starting and maintaining the heartbeat has also been reporte beta blockers.
DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent th pearance of certain premonitory signs and symptoms (pulse rate and pressure chang acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be difficult to adjust the dosage of insulin.
THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroi Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symp of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function
IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have reported in which, after propranolol, the tachycardia was replaced by a severe bradyc requiring a demand pacemaker. In one case this resulted after an initial dose of propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with imp hepatic or renal function. INDERAL is not indicated for the treatment of hyperte emergencies.
Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Pa should be told that INDERAL may interfere with the glaucoma screening test. Withdrawa lead to a return of increased intraocular pressure.
Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart dis elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.
DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as pine should be closely observed if INDERAL is administered. The added catechola blocking action may produce an excessive reduction of resting sympathetic nervous a which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or ortho hypotension.
Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals been conducted to evaluate toxic effects and carcinogenic potential. In 18-month stud both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of signi drug-induced toxicity. There were n[illegible]rug-related tumorigenic effects at any of the dc levels. Reproductive studies in animals did not show any impairment of fertility tha attributable to the drug.
Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryoto animal studies at doses about 10 times greater than the maximum recommended human There are no adequate and well-controlled studies in pregnant women. INDERAL s be used during pregnancy only if the potential benefit justifies the potential risk to the
Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised INDERAL is administered to a nursing woman.
Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and rarely required the withdrawal of therapy.
Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; tension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually Raynaud type.
Central Nervous System: lightheadedness; mental depression manifested by inso lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; disturbances; hallucinations; an acute reversible syndrome characterized by disorientati time and place, short-term memory loss, emotional lability, slightly clouded sensorium decreased performance on neuropsychometrics.
Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, dia constipation, mesenteric arterial thrombosis, ischemic colitis.
Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with a and sore throat, laryngospasm and respiratory distress.
Respiratory: bronchospasm.
Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocyto purpura.
Auto-Immune: In extremely rare instances, systemic lupus erythematosus has reported.
Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male tence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reac involving the skin, serous membranes and conjunctivae reported for a beta blocker (prac have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochlorid sustained-release capsule for administration once daily. If patients are switched from IND tablets to INDERAL LA capsules, care should be taken to assure that the desired therap effect is maintained. INDERAL LA should not be considered a simple mg for mg substitu INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitratio be necessary especially to maintain effectiveness at the end of the 24-hour dosing int
HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 8 INDERAL LA once daily, whether used alone or added to a diuretic. The dosage m increased to 120 mg once daily or higher until adequate blood-pressure control is achi The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage mg may be required. The time needed for full hypertensive response to a given dos variable and may range from a few days to several weeks.
ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDER once daily, dosage should be gradually increased at three to seven day intervals until opt response is obtained. Although individual patients may respond at any dosage leve average optimum dosage appears to be 160 mg once daily. In angina pectoris, the valu safety of dosage exceeding 320 mg per day have not been established.
If treatment is to be discontinued, reduce dosage gradually over a period of a few w (see WARNINGS).
MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDER once daily. The usual effective dose range is 160-240 mg once daily. The dosage m increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response obtained within four to six weeks after reaching the maximum dose, INDERAL LA th should be discontinued. It may be advisable to withdraw the drug gradually over a per several weeks.
HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.
PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group a limited to permit adequate directions for use.
*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Labora
895C

Ayerst® AYERST LABORATORIES
New York, N.Y. 10017

Federal Prospective Payment and the NJ Demonstration Waiver

VINCENT A. MARESSA, J.D.

The time has come for hospitals, the Health Department, and the legislature to find a solution to the problem of the New Jersey demonstration waiver.

The Administrator of the Health Care Financing Administration, Carolyne K. Davis, Ph.D., notified the Commissioner of Health that the federal demonstration waiver from the Secretary of Health and Human Services for the experimental cost control program being conducted in New Jersey was revoked, effective December 31, 1984. In her letter, Dr. Davis indicated that the New Jersey program failed to demonstrate it was less expensive than the federal form of reimbursement. Dr. Davis then gave the Health Department two options: 1) go into the federal system on January 1, 1985, or 2) qualify for a new waiver pursuant to the Social Security Amendments of 1983.

The Commissioner of Health and the New Jersey Hospital Association maintain that option #2 is the only viable course for New Jersey to follow. In order for New Jersey to qualify, however, a number of criteria must be met. These are:

1. The program must apply to substantially all acute care hospitals in the state and review at least 75 percent of all inpatient revenues or expenses of those hospitals. (Comment: New Jersey should be able to meet this standard.)

2. The program must provide equitable treatment to all payors, hospital employees, and patients. (Current actions in New Jersey afford different rules to different payors, i.e. union funds are "self-payors" and by passing payments through the patient can opt for DRG rates or charges, "self-payors," i.e. people with an uninsured exposure exceeding $250 can opt for charges, prompt payors get a discount, Blue Cross gets a prompt payor, and community service discount. (Comment: Whether this is "equitable" and meets the legal standard is a matter for debate.)

3. The program must not cost the federal government more than the federal DRG system would cost over a three-year period. (Comment: Since New Jersey produces about 35 percent outliers and provides compensation for indigent and teaching costs not covered in the federal program, compliance here is doubtful.)

4. The program must permit health maintenance organizations or other competitive medical plans to negotiate directly with hospitals concerning rates for inpatient services. (Comment: This requirement creates havoc with the all-payor concept and will produce a further cost shift by having Medicare and Medicaid pay a greater portion of indigent care.)

5. The program must not result in admission practices that reduce the level of treatment provided to uninsured low-income, high cost, or emergency patients. (Comment: New Jersey currently is meeting this standard.)

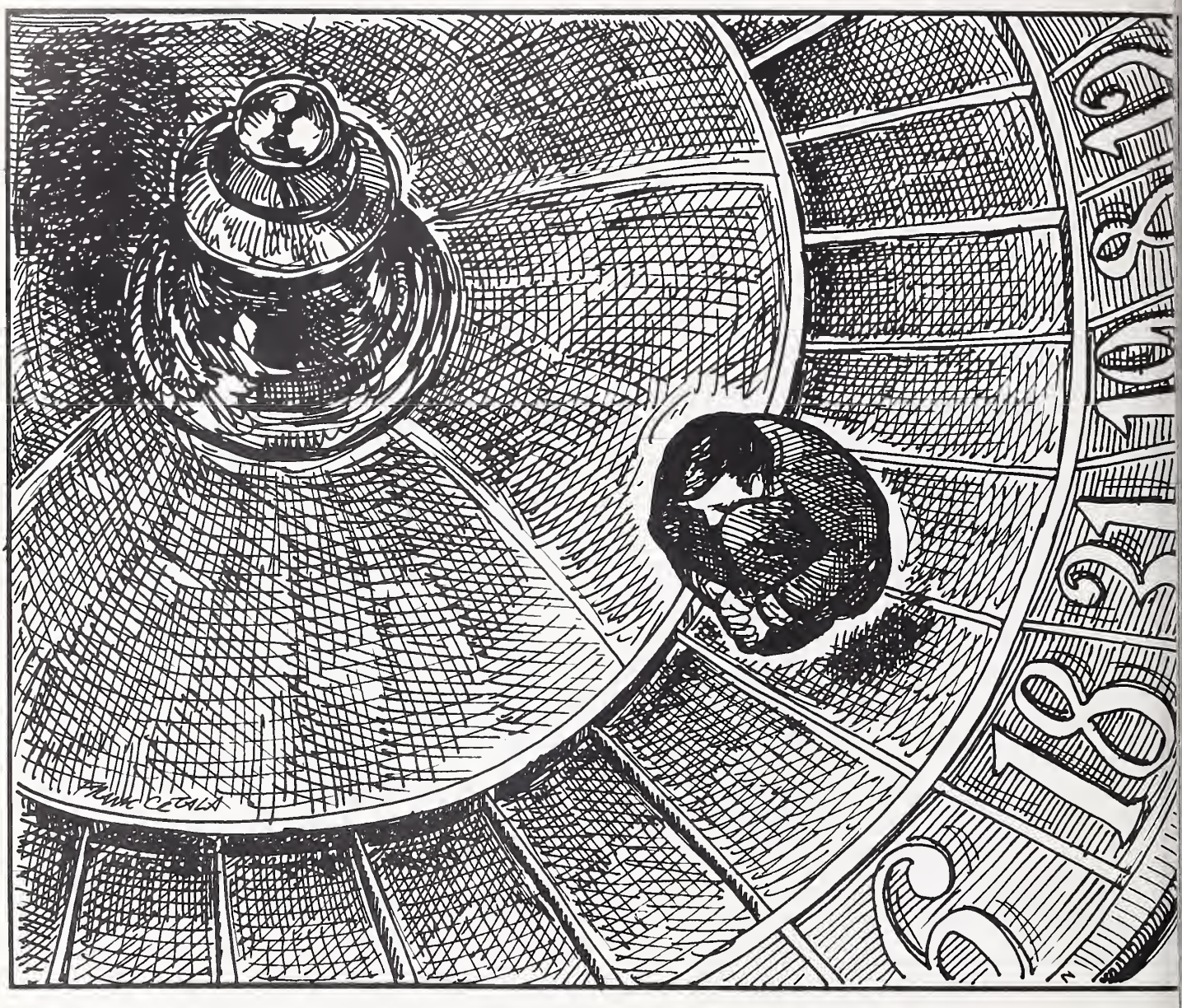
6. The program must use prospective payment methods. (Comment: This already is settled as a component of our system.)

A state with an existing demonstration waiver would have to meet the first 4 requirements listed above. There are 11 statutory requirements in all, but I did not believe the other 5 requirements necessary to this discussion. Since the New Jersey waiver has been "revoked," it would appear that the Health Department will have to submit an application that complies with the 11 statutory requirements.

There is a further subtle twist to the law. The Secretary of HHS cannot deny a waiver because Medicare payments exceed federal Medicare costs. The Secretary may reduce future Medicare payments to hospitals in that state to recoup overpayments. Thus, the overpayment would generate future credit lines, and the hospitals involved could find themselves in a real cash shortfall in future operating years.

Clearly, the current New Jersey practice of funding indigent and teaching costs by extra charges to the patients using our hospitals reduces the possibility of any acceptable performance as a waivered state. The time has come for all concerned hospitals, the Health Department, and the legislature to find a realistic solution. That solution is likely to be unpopular since the only workable one I can see is general tax revenue. I do not like taxes; however, I do not believe we can continue fooling ourselves.

*The material for this column is coedited by Arthur Krosnick, M.D., Editor, *The Journal*, MSNJ; Vincent A. Maressa, J.D., Executive Director, MSNJ; and James E. George, M.D., J.D., Director of Professional Liability, MSNJ.



COMPULSIVE GAMBLING

I first became involved with compulsive gambling six years ago in my first term as an Assemblyman. A woman concerned that her husband was gambling away the family's income called me to ask if there was anything I could do. She thought it a shame that the state so actively promoted legalize gambling and I agreed with her. I began looking in gambling and as I learned more about compulsi gamblers, the more I became involved in finding wa to help them.

Now, six years after that first talk, important pro

By Assemblyman Chuck Hardwick, Westfield

ess has been made. A full-time office on compulsive ambling has been opened, several conferences on ompulsive gambling have been held, and the public t large has become more aware of this devastating isease.

This year, New Jersey will derive roughly 7 percent f its budget—or $521 million—from legalized gamling. The basic tenet behind all my proposals to help ompulsive gamblers is the belief that since the state erives so much money from gambling, it has an obliation to help those who are hurt by it. It seems like uch a logical argument. But it has not been easy to onvince legislators and state administrators to contribute in some way to the treatment of compulsive amblers.

In 1982, I successfully sponsored an appropriation f $60,000 for seed money to begin a compulsive gamler's treatment project in New Jersey. (In 1980 and 981, former Governor Brendan Byrne vetoed the appropriation.) The funds, signed into New Jersey's 1982 o 1983 state budget by Governor Thomas Kean, were iven to the State Department of Health, which contracted with the National Council on Compulsive Gamling to form a New Jersey chapter. Last year, I was uccessful in having that appropriation increased to 200,000.

The program has focused on making the public ware of the problem of compulsive gambling through onferences, the press, and meetings with the private ector. At present, it would not be economically feasible or the state to fund a full medical treatment facility or compulsive gamblers. But I currently am investigating ways in which the gambling industry can help ontribute to the present program; this may generate nough funds to open an outpatient clinic, perhaps in Atlantic City.

Indeed, the past two years have seen a great deal of progress in defining the problem of compulsive gamling since the public approved of casino development n Atlantic City in 1978. The casinos have contributed n part to the frequency and visibility of compulsive gambling. The next step is to determine what sort of gambling procedures contribute to compulsive gamling. One of the most devasting procedures, I believe, s the way in which "casino credit" is distributed.

Simply, casino credit is money given to a gambler, nterest free, so he can continue gambling after his money has run out. When one looks into the casino credit issue, as I have done, one finds that casinos have wo types of credit: one for convenience; the other is because the gambler is flat broke.

I learned this after I conducted my own investigation by visiting casino officials, talking to gamblers, and working with a casino credit manager. I found that casino credit is given much too freely, often without regard for a person's ability to repay. The State Commission of Investigation, which conducted public hearings on casino credit abuse last spring, discovered the same sort of practices.

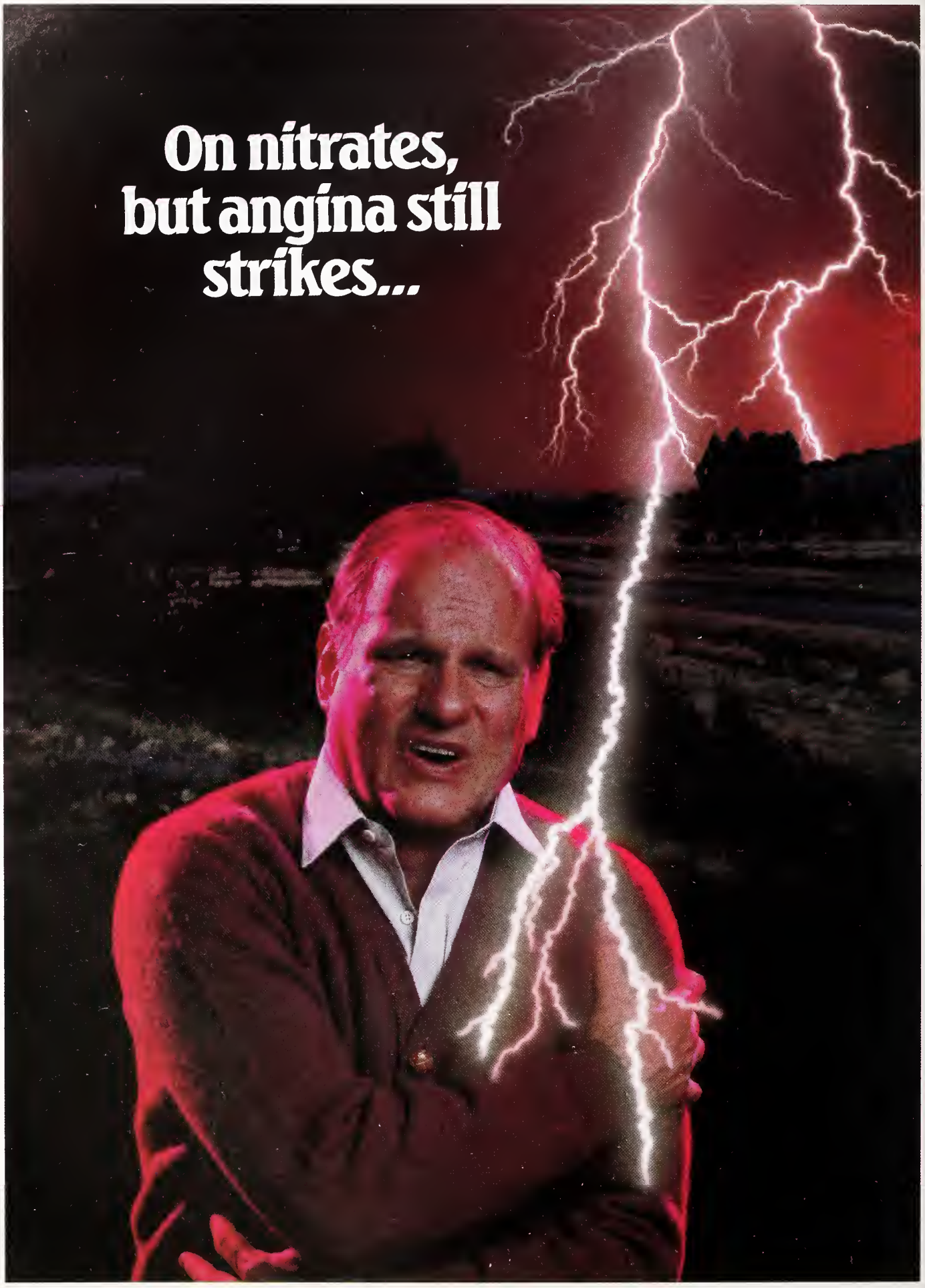
In an effort to remedy the casino credit situation, I have proposed three pieces of legislation:

- The first would prohibit casinos from giving additional credit to gamblers who already have checks or markers that have been returned for insufficient funds pending at any other casino. This would help prevent an indebted gambler from hopping from casino to casino to gamble himself further into debt or to borrow money from one casino to pay his debt at another casino.
- The second proposal would require casinos to wait 24 hours between the time a person applies for credit and the casinos issue it. This delay would allow the gambler time to reflect on his or her desire to continue gambling.
- My third proposal would remove the statute that permits casinos to deduct up to 4 percent of their winnings as uncollectable debts. This change would create a greater incentive for casinos to extend credit only to those who can repay. It would provide more funds for the elderly and the handicapped, who are helped by various programs through the Casino Revenue Fund.

Another of my proposals would require the gambling industry to contribute to the treatment of compulsive gamblers. It would levy a $25 annual fee on each of the nearly 12,000 slot machines in Atlantic City, all lottery ticket machines, and parimutuel ticket machines. The money would be used for the treatment of compulsive gamblers. For the present year, I was successful in negotiating an allocation of $75,000 to the University of Medicine and Dentistry of New Jersey from the State Lottery Commission to help fund a study to investigate the causes of compulsive gambling. By law, lottery money is distributed in part to higher education; these funds were awarded to UMDNJ for compulsive gambling research.

Legalized gambling is here to stay in New Jersey! What we must do is to learn how best to conduct it. A proposal of mine to form a Governor's Advisory Committee on Gambling currently is before the New Jersey Legislature. The Committee would consist of public officials, mental health experts, former compulsive gamblers, and other citizens who would study current gambling practices, designate problem areas, and recommend solutions.

*Assemblyman Chuck Hardwick is the Minority Whip. Correspondence may be addressed to Assemblyman Hardwick, 100 Quimby Street, Westfield, NJ 07090.


On nitrates,
but angina still
strikes...

After a nitrate, add ISOPTIN®
(verapamil HCl/Knoll)

To protect your patients, as well as their quality of life, add Isoptin instead of a beta blocker.

First, Isoptin not only reduces myocardial oxygen demand by reducing peripheral resistance, but also increases coronary perfusion by preventing coronary vasospasm and dilating coronary arteries — both normal and stenotic. These are antianginal actions that no beta blocker can provide.

Second, Isoptin spares patients the beta-blocker side effects that may compromise the quality of life.

With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin...for more comprehensive antianginal protection without side effects which may cramp an active life style.



ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page

ISOPTIN® TABLETS
(verapamil HCl/Knoll)
80 mg and 120 mg

Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction <30%) or moderate to severe symptoms of cardiac failure. Control milder heart failure with optimum digitalization and/or diuretics before ISOPTIN is used. ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild, and controlled by decrease in ISOPTIN dose). Occasional elevations of liver enzymes have been reported; patients receiving ISOPTIN should have liver enzymes monitored periodically. Patients with atrial flutter/fibrillation and an accessory AV pathway (e.g., W-P-W or L-G-L syndromes) may develop a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion. AV block may occur (3rd degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema, and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with ISOPTIN. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, patients should be monitored closely. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function or in patients who have also recently received methyldopa. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patient carefully monitored. ISOPTIN may have an additive hypotensive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR<50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%). The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: confusion, paresthesia, insomnia, somnolence, equilibrium disorders, blurred vision, syncope, muscle cramps, shakiness, claudication, hair loss, maculae, and spotty menstruation. Overall continuation rate of 94.5% in 1,166 patients. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in 80 mg and 120 mg sugar-coated tablets. July 1982 2068

knoll® KNOLL PHARMACEUTICAL COMPANY
30 NORTH JEFFERSON ROAD, WHIPPANY, NEW JERSEY 07981

2195

My Patients Were Fine...
My Practice Was Ailing!



My Remedy:
EXECU-FLOW SYSTEMS...
"A Good Shot In The Arm!"



Computers are revolutionizing the practice of medicine. Execu-Flow Systems is at the forefront of this revolution, providing you with the latest in software/hardware technology.

You can start with Patient Billing and Insurance Processing, and add other systems such as Appointment Scheduling, Medical Records, Electronic Claims, Word Processing, etc.

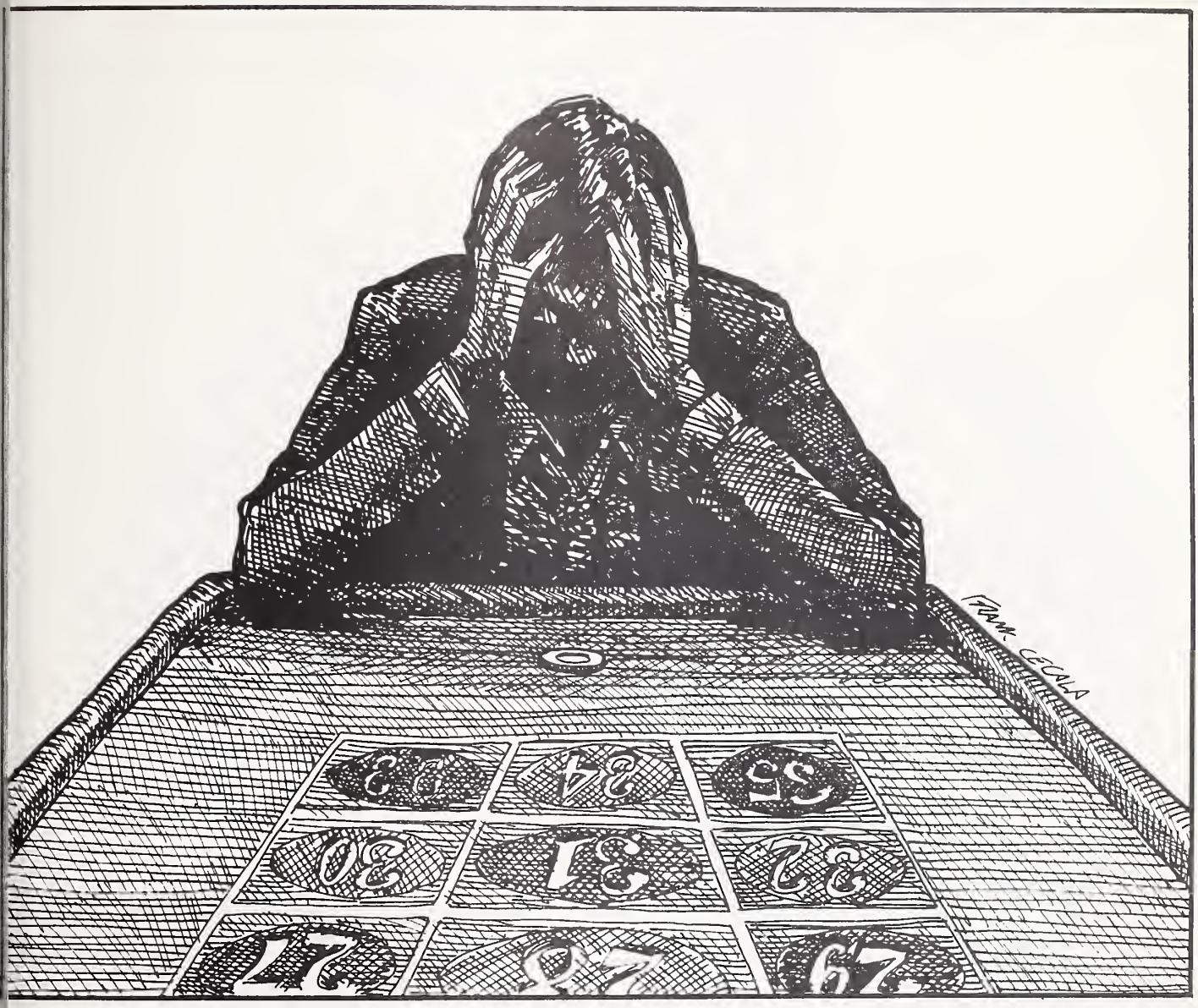
Our many years of experience with practices such as yours, **GUARANTEES** our mutual success. Our system provides you with the peace-of-mind in knowing that your practice is operating at peak efficiency.

Could *your practice* use a *"Shot in the Arm?"*

- **Multi-tasking** IBM XT/IBM 9000/ CONTEL CADO Systems
- Software for *YOUR SPECIALTY*
- Automatic Prescription System
- Complete "Paperless" Office Available
- Comprehensive Patient Recall System

EXECU-FLOW SYSTEMS INC

2013 Morris Avenue, Union, N.J. 07083
or call (201) 851-0750



NEW JERSEY COMBATS COMPULSIVE GAMBLING

The Council on Compulsive Gambling of New Jersey, Inc., an affiliate of The National Council Compulsive Gambling, has been operational since nuary 1983. An appropriation of funds in the 1983 w Jersey State budget provided money to hire a director and to establish the office of The Council on Compulsive Gambling of New Jersey, Inc. The Council was incorporated as a private, nonprofit health agency and has received a contract from the state of New Jersey to render a variety of services for the benefit of the general public affected by compulsive gambling

By Robert M. Klein

COMPULSIVE GAMBLING

At a statewide meeting, The Council on Compulsive Gambling of New Jersey, Inc., highlighted its present programs, including a 24-hour hotline service and a state networking system. The Council plans additional services to help compulsive gamblers in the state.

and for the professional community which ministers to them.

The Council has developed and promoted a statewide public education and information campaign. To this end, several of our goals already are in place. Our Trenton office provides agency and referral services during business hours. We can be reached at 609-599-3299. Our hotline number for help in New Jersey is functioning smoothly and successfully. Anyone calling 800-G-A-M-B-L-E-R, 24 hours a day, seven days a week, is put in contact with someone who understands and can help. Network and cable TV, radio and newspapers, and our own correspondence and literature, publicize this number.

Approximately 150 persons attended our North Jersey and South Jersey seminars, which were geared toward training of professional care providers. Our purpose was to heighten their awareness in identification, and expertise in treating and referring compulsive gamblers and their families.

Our First Annual Statewide Conference on Compulsive Gambling took place on September 28, 1983. We are gratified and proud that this landmark event was a cooperative venture with the Medical Society of New Jersey. The Council is indebted to Dr. David I. Canavan, Medical Director of the Impaired Physicians Program, for his great contributions to assure the success of this day-long conference. More than 20 physicians along with psychologists, social workers, rehabilitation counselors, and representatives from the mental health and criminal justice systems were attendance. Evaluation indicated that the presente were very well received, and that areas vital to t attending professionals had been addressed.

The Council on Compulsive Gambling of New Jers is involved in networking with a great many agenci organizations, and community leaders, in order serve better the citizens of New Jersey.

A Blue Ribbon Task Force on Compulsive Gambli has been established to develop a dialogue among wide spectrum of professional disciplines. It is hop that an awareness of this hidden illness will be cor municated to the constituencies of this Task Forc Input from the Task Force members will be invaluab in helping The Council to reach its objectives ar goals.

The Council is working to collect data on the gar bling problem in New Jersey. For example, one r markable statistic is that in 1982, of the 250,0 people brought to Atlantic City by a chartered bu company, 75 percent of the passengers were seni citizens. We particularly must consider the needs students and women.

We owe so very much to so many: our staff, Boa of Directors, Advisory Board, Council members, ar friends.

*Mr. Klein is Executive Director, The Council on Compulsi Gambling of New Jersey, Inc., Trenton.

BALANCED CALCIUM CHANNEL BLOCKADE!



Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:

1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
3. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

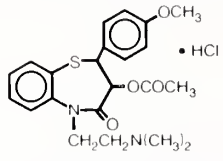
Please see full prescribing information on following page.

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), asthenia (1.2%), AV block (1.1%). In addition, the follo were reported infrequently (less than 1%) with the order tion corresponding to the relative frequency of occurre

Cardiovascular:	Flushing, arrhythmia, hypotensic dia, palpitations, congestive h syncope.
Nervous System:	Paresthesia, nervousness, s tremor, insomnia, hallucinations,
Gastrointestinal:	Constipation, dyspepsia, diarrhe mild elevations of alkaline phosph SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, pho
Other:	Polyuria, nocturia.

The following additional experiences have been not

A patient with Prinzmetal's angina experiencing vasospastic angina developed periods of transient a asystole approximately five hours after receiving a s dose of CARDIZEM.

The following postmarketing events have been re quently in patients receiving CARDIZEM: erythema mu kopenia; and extreme elevations of alkaline phospha SGPT, LDH, and CPK. However, a definitive cause and ef these events and CARDIZEM therapy is yet to be esta

OVERDOSAGE OR EXAGGERATED RESPO

Overdosage experience with oral diltiazem has b Single oral doses of 300 mg of CARDIZEM have been v by healthy volunteers. In the event of overdosage or response, appropriate supportive measures should be addition to gastric lavage. The following measures may b

Bradycardia	Administer atropine (0.60 to 1.0 is no response to vagal blockad isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. degree AV block should be trea diac pacing.
Cardiac Failure	Administer inotropic agents (is dopamine, or dobutamine) and di
Hypotension	Vasopressors (eg, dopamine or bitartrate).

Actual treatment and dosage should depend on the s clinical situation and the judgment and experience of physician.

The oral/LD_{50}'s in mice and rats range from 415 t and from 560 to 810 mg/kg, respectively. The intraven these species were 60 and 38 mg/kg, respectively. Th dogs is considered to be in excess of 50 mg/kg, while seen in monkeys at 360 mg/kg. The toxic dose in man i but blood levels in excess of 800 ng/ml have not bee with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclı nary Artery Disease or Angina Pectoris at Rest D nary Artery Spasm. Dosage must be adjusted to e needs. Starting with 30 mg four times daily, before bedtime, dosage should be increased gradually (give doses three or four times daily) at one- to two-day i optimum response is obtained. Although individual respond to any dosage level, the average optimum d appears to be 180 to 240 mg/day. There are no available ing dosage requirements in patients with impaired ren function. If the drug must be used in such patients, titrat carried out with particular caution.

Concomitant Use With Other Antianginal Age

1. **Sublingual NTG** may be taken as required to anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM m coadministered with short- and long-acting nitrat have been no controlled studies to evaluate th effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIC

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles 0088-1771-47) and in Unit Dose Identification Paks 0088-1771-49). Each green tablet is engraved with MA side and 1771 engraved on the other. CARDIZEM 6 tablets are supplied in bottles of 100 (NDC 0088-1772-4 Dose Identification Paks of 100 (NDC 0088-1772-49) tablet is engraved with MARION on one side and 1772

Is

Another patient benefit product from

PHARMACEUTICAL DIVISION
MARION LABORATORIES, INC.
KANSAS CITY, MISSOURI 64137

Aortic and Mitral Valve Replacement: Part 2*

Philip Olivieri, M.D., and John Kostis, M.D., New Brunswick**

The results of surgical management compared to medical management of the valvular lesions are presented. The hemodynamic consequences of surgery and the validity of noninvasive guidelines for timing surgical intervention are discussed. Special situations involving the repair of native valves and the replacement of valve prostheses are reviewed.

The value of valve replacement clearly has been established in acute aortic and mitral regurgi-nt lesions and in chronic valvular lesions when the tient is symptomatic. However, the need for and tim-g of surgical intervention in chronic valvular disease asymptomatic or minimally symptomatic patients controversial. Rahimtoola has cautioned that the sks of early valve replacement (operative mortality, rioperative myocardial damage, questionable long-rm prosthetic performance, and influence on yocardial function) should be weighed carefully ainst the possible symptomatic relief and increased rvival resulting from a successful operation.[4] De-ite detailed attempts to create rational guidelines for rgical intervention in these patients, the decision to change "native valve disease for prosthetic valve dis-se" remains to a large extent a matter of clinical dgment.[5,6]

ORTIC STENOSIS

It is useful to separate operative or inhospital mor-lity from long-term mortality in assessing the benefit any valvular surgery. In general, operative mortality 5 percent or greater for single and 10 percent or eater for double valve replacement.[31] Aortic valve re-acement usually is thought to have a more favorable ng-term prognosis than mitral valve replacement hough some authors dispute this.[23,32] The early results of aortic valve replacement were poor due to high operative mortality. Rotman et al. reported a series of 39 patients with aortic stenosis who underwent 43 procedures (36 replacements and 6 valvulotomies) with an operative mortality of 31 percent.[15] Improvements in surgical technique such as cold cardioplegia with potassium arrest, postsurgical management with pulmonary arterial balloon-flotation catheters and afterload reducing drugs, and valve prostheses dramatically have changed the figures. The 7 percent operative mortality in a recent study by Schwarz et al. is typical and the 3.5 percent mortality cited by Cobbs et al. is not uncommon.[17,33]

The results of several surgical series are presented in Table 1. Surgical therapy clearly is superior to medical therapy in the presence of significant aortic stenosis. Schwarz et al. reported 87 percent 3-year survival by life-table analysis in a 125-patient operative group versus 21 percent 3-year survival in a 19-patient nonoperative group. The data of Schwarz et al. are compared to composite data for the natural history of the disease in Figure 1.

The indications for surgery in aortic stenosis are

*Part 1 appeared in the previous issue of *The Journal*, MSNJ.

**From the Division of Cardiovascular Diseases, UMDNJ-Rutgers Medical School. Correspondence may be addressed to Dr. Kostis, UMDNJ-Rutgers Medical School, CN 19, New Brunswick, NJ 08903.

TABLE 1

Results of Surgical Intervention

Aortic Stenosis	
Rotman et al. 1971[15]	Series of 39 patients with aortic stenosis, underwent 43 procedures (37 replacements and 6 valvulotomies) with operative mortality 31 percent. Series of 24 patients with stenosis/regurgitation, underwent 26 procedures (23 replacements and 3 valvulotomies) with operative mortality 25 percent.
Munoz et al. 1975[23]	Series of 47 patients with all types of aortic valve disease underwent aortic valve replacement with operative mortality 27 percent and 70 percent 5-year survival.
Smith et al. 1978[34]	Series of 10 patients with severe aortic stenosis and congestive heart failure underwent valve replacement with operative mortality 21 percent and 74 ± 10 percent actuarially predicted 3-year + 5-year survival.
Carabello et al. 1980[43]	Series of 14 patients with severe aortic stenosis and congestive heart failure underwent valve replacement with operative mortality 21 percent. Group I (10 of 11 with improvement): afterload mismatch. Group II (1 of 11 with no improvement + 3 operative fatalities): depressed contractility.
Schwarz et al. 1982[17]	Series of 125 surgical patients with operative mortality 7 percent and actuarially predicted 87 percent 3-year survival versus 19 medically treated patients with 21 percent survival.
Mitral Stenosis	
Bonchek et al. 1974[46]	Series of 150 patients with all types of mitral valve disease underwent mitral valve replacement with operative mortality 2 percent and actuarially predicted 85 percent 5-year survival (40 of 150 with pure mitral stenosis).
Munoz et al. 1975[23]	Series of 118 patients with mitral stenosis who underwent open mitral commissurotomy with operative mortality of 5 percent. Series of 45 patients with all types of mitral valve disease who underwent valve replacement with operative mortality 24 percent and 60 percent 5-year survival.
Ward and Hancock 1975[49]	Series of 27 patients with severe mitral valve disease and pulmonary hypertension underwent mitral valve replacement with 56 percent 5-year survival. Group of 21 similar patients managed medically had 10 percent 5-year survival.
Hammermeister et al. 1978[30]	Series of 249 patients with all types of mitral valve disease: 74 percent 5-year survival in surgical group *v* 62 percent survival in medical group. Group of 45 patients with mitral stenosis/regurgitation and 85 percent 5-year survival in group of 22 medically managed patients.
Dalby et al. 1981[50]	Series of 545 patients with all types of mitral valve disease (stenosis 160, regurgitation 76, and stenosis/regurgitation 309) underwent mitral valve replacement with 7 percent operative mortality. Increased cardiothoracic ratio, left atrial size, or poor hemodynamics prognostic.
Gross et al. 1981[45]	Series of 202 patients with mitral stenosis underwent open mitral commissurotomy with operative mortality 1.7 percent and actuarially predicted 92 percent 10-year survival.
Rutledge et al. 1982[44]	Series of 303 patients with mitral stenosis underwent closed mitral commissurotomy between 1954 and 1980 with an operative mortality of 2 percent and actuarially predicted survivals of 95 percent at 5 years, 82 percent at 10 years, and 70 percent at 15 years. Subgroup of 54 patients underwent valve replacement at mean 9.6 years with operative mortality of 13 percent and actuarially predicted 95 percent 5-year and 74 percent 10-year survivals.
Aortic Regurgitation	
Rotman et al. 1971[15]	Series of 30 patients with aortic regurgitation underwent 31 procedures (30 replacements and 1 homograft) with operative mortality 16 percent.
Henry et al.	I. Series of 50 symptomatic patients with 49 of 50 good echocardiograms: 100 percent (49 of 49) had left ventricular dilatation, 29 percent (14 of 49) had fractional shortening less than 25 percent. Operative mortality 6 percent. Late mortality 16 percent at 5 to 43 months; 8 of

continued

TABLE 1

Results of Surgical Intervention

	49 with congestive heart failure. Overall 43-month survival 77 percent. High-risk group (left ventricular end-systolic diameter above 55 mm, fractional shortening below 25 percent) accounted for 69 percent (9 of 13) early + late mortality. II. Series of 37 symptomatic patients with serial echocardiograms and mean followup of 34 months: 38 percent (14 of 37) subsequently operated *v* 62 percent (23 of 37) nonoperated (remained asymptomatic).
Greves et al. 1981[51]	Series of 45 patients with severe isolated aortic regurgitation underwent valve replacement with 4.4 percent operative mortality; actuarially predicted 85 percent 5-year survival in 39 patients.
Kumpuris et al. 1982[57]	Group A (postaortic valve replacement normalization of left ventricular function) with no congestive heart failure or death. Group B (postsurgical progression with 43 percent failure and 29 percent mortality.
Bonow et al. 1982[54]	Series of symptomatic patients with 85 percent 2-year and 63 percent 4-year survival. Operative morality 6 percent. High-risk group contained low-risk subgroup with preserved exercise capacity.
Schwarz et al. 1982[17]	Surgical series with operative mortality 7 percent and actuarially predicted 86 percent 5-year survival *v* 87 percent 5-year survival in medical cohort.
	Mitral Regurgitation
Hammermeister et al.	Series of 61 surgical patients with 70 percent 5-year survival *v* 54 percent 5-year survival among 36 medically managed patients.
Phillips et al.	Series of 105 patients with mitral regurgitation underwent valve replacement with 4 percent operative mortality and 82 percent actuarially predicted 5-year survival. Only age above 60 years or preoperative ejection fraction less than 40 percent predicted decreased 5-year survival.

ummarized in Table 2. The decision to recommend urgery in symptomatic patients in order to prolong fe and to provide relief is straightforward. Prompt peration is indicated even in those with severe con-estive heart failure or ejection fraction less than 20 ercent.[34,35] Age should not be a barrier to surgical ntervention since benefit has been demonstrated even n those greater than 70 years.[36] Surgery in symptomatic patients depends upon hemodynamic tatus: surgery is indicated to decrease the risk of udden death in the presence of a transvalvular gra-ient greater than 50 mm/Hg and/or a valve area less han 0.4 cm^2/m^2 body surface area.

Aortic valvulotomy rarely is possible in the adult opulation. Calcification of the aortic valve uniformly s present in adult aortic stenosis rendering alvulotomy technically impossible without the crea-ion of unacceptable aortic regurgitation. Accordingly, he procedure of choice is replacement of the aortic alve with a mechanical or bioprosthesis.

A controversy recently has arisen concerning the eed for preoperative cardiac catheterization in pa-ients undergoing valve replacement. St. John Sutton t al. and Brandenburg have suggested that cardiac atheterization can be avoided in selected patients by linical assessment and echocardiography.[37,38] Hakki et l., O'Rourke, and Rahimtoola among others have pres-nted detailed arguments stressing the need for atheterization in the great majority of patients.[39-41] Catheterization is required to determine the severity f the valvular lesion, to detect hidden associated alvular disease, to definitively assess the degree of left entricular dysfunction, and to evaluate the coronary arteries. It seems prudent, at the present time, to continue the practice of preoperative cardiac catheterization and coronary arteriography in all candidates for valvular surgery.

Significant coronary arterial stenosis should be bypassed at the same surgery which corrects the valvular lesions. Combined valve and coronary artery bypass surgery can be performed with a similar operative risk and late results as valve replacement alone.[42]

The left ventricular response to the pressure overload imposed by chronic aortic stenosis has been reviewed by Ross.[35] Following an initial period of relative left ventricular decompensation, concentration hypertrophy develops with a return to normal cardiac output. Hyperfunction is evidenced by the leftward shift of the pressure versus ventricular volume curve (Figure 2). However, the relation of wall stress to ventricular diameter remains linear, demonstrating normal contractility. With decreasing contractility, this relation is shifted downward and to the right. Following successful valve replacement, the hypertrophy regresses and the left ventricular function either remains normal or returns to normal within six months. Ross concludes, "Mechanical overload per se rather than irreversible depressed myocardial contractility primarily is responsible for reduced left ventricular function preoperatively in many patients, although in a few, depressed contractility is clearly important."[35] This concept is supported by the report of Carabello et al. who described 14 patients with critical aortic stenosis (valve area less than 0.4 cm^2/m^2) and congestive heart failure submitted to valve replacement.[43] There were 3 operative deaths (operative mortality 21

TABLE 2

Indications for Valvular Surgery

Aortic Stenosis	
Symptomatic:	Surgery recommended
Asymptomatic:	Surgery recommended if: a. Transvalvular gradient greater than 50 mm/Hg and/or b. Valve area less than 0.4 cm^2/m^2 body surface area Advanced age no barrier to surgery
Mitral Stenosis	
Symptomatic:	Surgery recommended
Asymptomatic:	Surgery recommended if: a. Special circumstances such as systemic embolization b. Evidence of progressive pulmonary hypertension
Aortic Regurgitation	
Symptomatic:	Surgery recommended
Asymptomatic:	Surgery recommended if: a. M-mode echocardiographic left ventricular end-systolic diameter greater than 55 mm; or b. M-mode echocardiographic fractional shortening less than 25 percent and invasive study confirms left ventricular dysfunction The noninvasive criteria do not apply to a small subset of patients in whom exercise capacity is preserved.
Mitral Regurgitation	
Symptomatic:	Surgery not recommended if symptoms can be satisfactorily controlled by standard medical therapy. Disease not necessarily progressive. Surgery recommended if there is evidence of progressive left ventricular dysfunction and deterioration.
Asymptomatic:	Surgery not recommended if condition remains stable. Surgery recommended if: a. M-mode echocardiographic left ventricular end-diastolic diameter greater than 80 mm; or b. M-mode echocardiographic left ventricular end-systolic diameter greater than 50 mm; or c. M-mode echocardiographic fractional shortening less than 30 percent; d. M-mode echocardiographic ejection fraction less than 55 percent; and invasive study confirms left ventricular dysfunction.

percent) and 11 survivors. Ten of the survivors who showed substantial improvement comprised Group I. A linear relation was found between the ejection fraction and left ventricular wall stress in Group I consistent with afterload mismatch. The 3 operative fatalities and 1 unimproved survivor comprised Group II. A lowered ejection fraction for a given left ventricular wall stress was found in Group II, consistent with decreased contractility. Thus, the concept of afterload mismatch (inappropriate hypertrophy for the imposed afterload) can help to explain the beneficial effect of surgery in most patients.

MITRAL STENOSIS

The first surgical therapy in valvular heart disease was mitral valvulotomy for mitral stenosis. Rowe et al. in their classic study of the natural history of mitral stenosis included the early data from Harken's group showing the benefits of that procedure.[20] Mitral commissurotomy continues to be the ideal "first procedure" in surgical candidates with suitable valve pathology (noncalcified, mobile leaflets). While open mitral commissurotomy currently is the procedure of choice among most surgeons, closed mitral commissurotomy equally is safe and remains useful in experienced hands. Rutledge et al. reported a series of 303 patients who underwent closed mitral commissurotomy for acquired, isolated mitral stenosis between 1954 and 1980 with an operative mortality of

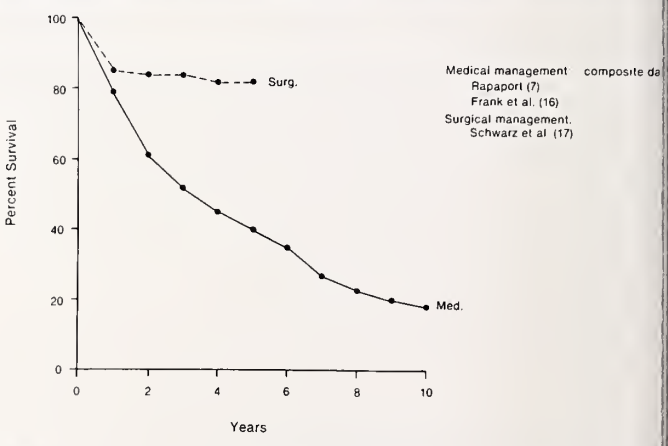


Figure 1—Aortic stenosis: Survival data for medical vers surgical management.

2 percent.[44] Gross et al. reported a series of 202 p tients who underwent open mitral commissurotom between 1967 and 1978 with an operative mortality 1.7 percent.[45]

Those patients whose valves are not suitable fc commissurotomy or in whom commissurotomy ha failed must undergo mitral valve replacement. Th procedure carries a higher operative mortality than th simpler commissurotomy. Kirklin and Pacifico cite surgical series reviewed by Kouchoukos with a hosp tal mortality of 5 percent for pure mitral stenosis Boncheck reported a series of 150 patients (includin 40 patients with mitral stenosis) who underwent ele

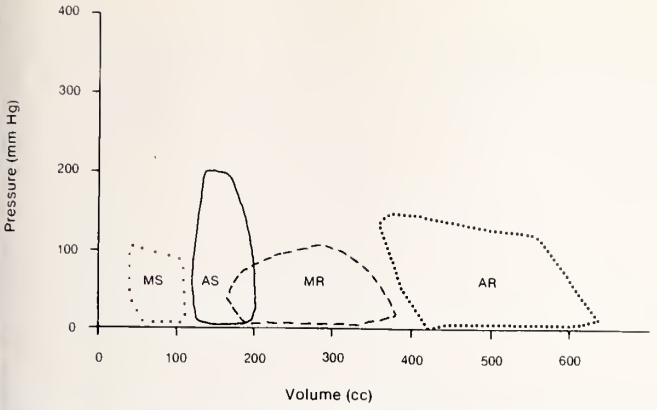


Figure 2—Pressure versus ventricular volume in valvular heart disease.

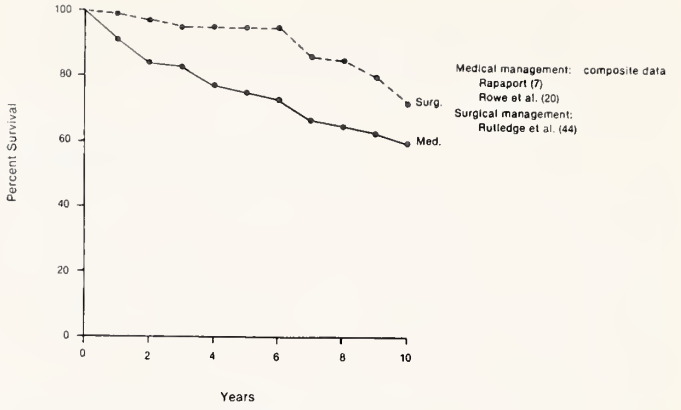


Figure 3—Mitral stenosis: Survival data for medical versus surgical managment.

ive mitral valve replacement with only 2 percent operative mortality.[46]

The results of several surgical series are presented n Table 1. Munoz et al. demonstrated the superiority of surgical therapy in mitral stenosis.[23] They found an 85 percent 5-year survival in 118 patients undergoing open mitral commissurotomy with an operative mortality of 5 percent. The 5-year survival in a medically treated group of 58 patients with mitral stenosis was 45 percent. The report of Rutledge et al. particularly s useful because it showed that an initial or even repeat mitral commissurotomy does not prejudice the results of later mitral valve replacement. The actuarially predicted 5-, 10-, and 15-year survival in the 303 patients were 95 percent, 82 percent, and 70 percent, respectively. Fifty-four patients (18 percent) subsequently underwent mitral valve replacement at a mean of 9.6 years. The indications were residual stenosis with or without mild regurgitation in 33 patients (61 percent), restenosis in 15 (28 percent), and moderate-to-severe mitral regurgitation in 6 (11 percent). The operative mortality was 13 percent and the actuarially predicted 5- and 10-year survivals were 95 percent and 74 percent, respectively. The data of Rutledge et al. for mitral valve replacement are compared to composite data for the natural history of the disease in Figure 3.

The indications for surgery in mitral stenosis are summarized in Table 2. Surgery is recommended in symptomatic patients in order to improve functional status and provide symptomatic relief. Thus, patients n New York Heart Association classes III and IV are surgical candidates. Asymptomatic (class I) patients are not ordinarily surgical candidates except in special circumstances such as following an episode of systemic embolization. The class II patient presents a therapeutic dilemma. Close followup is indicated and a high ndex of suspicion for pulmonary hypertension should be maintained.

As noted, mitral commissurotomy (either open or closed) is the procedure of choice in suitable patients. Those with residual stenosis or restenosis may undergo a second commissurotomy with beneficial results although Rutledge et al. found a positive correlation between repeat commissurotomy and subsequent mitral valve replacement. Insertion of a prosthetic device can be performed with a low operative mortality and good long-term results, especially on an elective basis when class IV patients or patients with severe pulmonary hypertension are avoided by early surgery. Patients aged 30 years or younger with severe symptoms, with physical signs of isolated severe mitral stenosis, and appropriate noninvasive finding are among the small group of patients that may be excluded from preoperative cardiac catheterization.[40]

Although stroke volume and cardiac output are reduced in the presence of mitral stenosis, the function of the left ventricle is fairly well preserved (Figure 2). Unsuspected deterioration of the left ventricular function does not occur. Flessas and Ryan have reported that patients with mitral stenosis demonstrate a normal chronotropic and pressor response to isometric exercise.[47] Wroblewski et al. have reported that the right ventricle performs normally in patients with moderate pulmonary hypertension, maintaining normal size and ejection fraction.[48]

Following successful surgery, substantial reduction in left atrial and pulmonary pressures should occur. Patients in whom surgery has been delayed until the development of irreversible pulmonary hypertension are at great risk. The series of Ward and Hancock is instructive: 27 patients with severe pulmonary hypertension and mitral valve disease underwent valve replacement with a 56 percent 5-year survival.[49] A similar group of 21 patients treated medically had a 10 percent 5-year survival. Thus, pulmonary hypertension should be considered an indication for surgery even though the surgical risk is high since the nonsurgical prognosis is dismal. This concept is supported by the report of Dalby et al., who studied preoperative factors affecting the outcome of isolated mitral valve replacement.[50] They found increased operative mortality in patients with a large cardiothoracic ratio, a large left atrium, and "poor hemodynamics." Poor hemodynamics were defined as combinations of cardiac index less than 1.5 liters/min/m^2, systolic pulmonary arterial pressure greater than 100 mm/Hg, pulmonary vascular resistance greater than or equal to 10 units, or left ventricular end-diastolic pressure of 20 mm/Hg or greater. However, they also found that the long-term prognosis in those patients was no different from patients without the preoperative abnormalities. Clearly, there is a need for meticulous perioperative care in the compromised patients in order to reap the long-term benefits of surgery.

AORTIC REGURGITATION

The regurgitant lesions of the aortic and mitral

valves impose a volume overload on the left ventricle. However, the loading conditions are such that chronic compensation is possible and each lesion therefore is characterized by long latency. During the latent periods, irreversible myocardial damage can occur and it is this fact which is responsible for the therapeutic dilemma in timing surgical intervention. The current operative mortality is an important factor in the decision to recommend surgery. A high operative risk would tend to postpone the decision to undergo surgery whereas a low risk would allow the patient to obtain the benefits of earlier intervention.

As noted in the discussion of aortic stenosis, the early results of aortic valve replacement were poor due to high operative mortality. Rotman et al. reported a series of 30 patients with aortic regurgitation who underwent 31 procedures (30 replacements and 1 homograft) with an operative mortality of 16 percent.[15] Later studies reflect not only the improvements cited in the discussion of aortic stenosis, but also an increased understanding of the pathophysiology of regurgitant lesions. Greves et al. recently reported a series of 45 patients who underwent aortic valve replacement for severe isolated aortic regurgitation between 1973 and 1979 with an operative mortality of 4.4 percent.[51]

The results of several surgical series are presented in Table 1. Schwarz et al. reported 86 percent 5-year survival by life-table analysis in a 127-patient operative group versus 87 percent 5-year survival in a 13-patient nonoperative group.[17] They concluded, "Aortic valve replacement does not change long-term survival in patients with aortic regurgitation, although those with left ventricular dysfunction tended to live longer." The data of Schwarz et al. are compared to composite data for the natural history of the disease in Figure 4.

In March 1980, a two-part prospective study by Henry et al. entitled, "Observations on the Optimum Time for Operative Intervention for Aortic Regurgitation," appeared in *Circulation*.[52] Part I presented the results of aortic valve replacement in 50 symptomatic patients. The operative mortality was 6 percent and the overall survival at 43 months was 77 percent. Forty-nine patients had good quality echocardiograms and formed the basis for the study. They found 100 percent of the patients had left ventricular dilatation and 29 percent had fractional shortening less than 25 percent. A high-risk group of 13 patients with left ventricular end-systolic diameter greater than 55 mm and a fractional shortening less than 25 percent was identified. A 69 percent mortality (9 of 13 patients, combined early and late deaths) occurred in this group. Part II presented the results of 37 asymptomatic patients with serial echocardiograms and a mean followup of 34 months. Fourteen patients (38 percent) developed symptoms and went to surgery: the "subsequently operated" group. Twenty-three patients (62 percent) remained asymptomatic: the "nonoperated" group. The left ventricular end-systolic diameter was 53.0 mm in the subsequently operated group versus 44.3 mm in the nonoperated group. The fractional shortening was 28.8 percent in the subsequently operated group versus 33.9 percent in the nonoperated group. The maximum rate of change of the left ventricular end-systolic diameter was greater than 7 mm/year in only 1 patient.

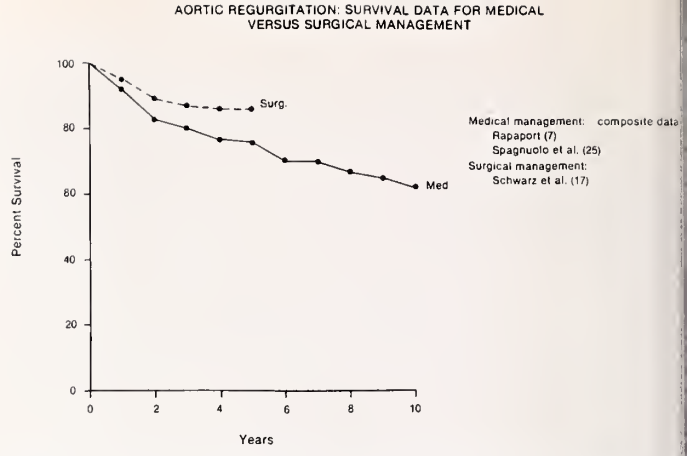


Figure 4—Aortic regurgitation: Survival data for medical versus surgical management.

On the basis of these data, Henry et al. proposed that a low-risk group with left ventricular end-systolic diameter less than 50 mm could be followed safely at yearly intervals with medical management.[52] A high-risk group with left ventricular end-systolic diameter greater than 55 mm identified potential surgical candidates for valve replacement requiring further study. In an editorial comment on the report of Henry et al. O'Rourke and Crawford stressed the need for individual assessment of the asymptomatic patient with severe aortic regurgitation and noted that the left ventricular end-systolic criteria were suggestive but not proved.[53]

Bonow et al. reported that the low-risk group with aortic regurgitation defined by Henry et al. had survival comparable to aortic stenosis patients with aortic valve replacement.[54] They also identified a low-risk subgroup within the previously defined high-risk group characterized by preserved exercise tolerance (completion of Stage I of the National Institutes of Health exercise protocol). Retained exercise capacity did not correlate with either left ventricular end-systolic diameter or fractional shortening; it independently predicted a good postoperative prognosis.

The noninvasive guidelines proposed by Henry et al. and Bonow et al. would appear to provide a rational basis for the appropriate timing for surgical intervention in aortic regurgitation. However, there are difficulties in reproducing echocardiographic data. Rahimtoola cites a study by Turina et al. presented to the Working Group of the European Society of Cardiology on Valvular Prostheses (Lyon, France; October 1979) in which the results of Henry et al. were not duplicated.[41]

The indications for surgery in aortic regurgitation are summarized in Table 2. The benefit of surgery in symptomatic patients for relief of symptoms and prolongation of life is established. This is not the case in asymptomatic patients. They should be followed closely utilizing the guidelines discussed above to anticipate the development of left ventricular dysfunction. A small number of severely symptomatic patients aged 30 years or younger with physical signs of isolated severe chronic aortic regurgitation may be candidates for valve replacement without preoperative cardiac catheterization.[40] However, the great majority of symptomatic patients and all asymptomatic patients should not undergo valve replacement without invasive studies.

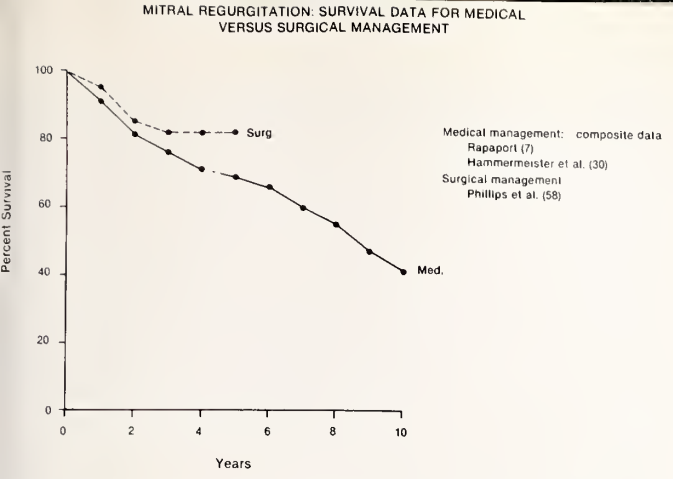


Figure 5—Mitral regurgitation: Survival data for medical versus surgical management.

It may be possible on rare occasions to repair the ortic valve, especially in patients in whom regurgiation is due to aneurysmal dilatation of the annulus nd aortic root. In most cases, however, aortic valve eplacement is the procedure of choice. Reparative rocedures have a tendency to deteriorate in the high ressure and stress aortic position.

Having discussed aortic valve replacement in both ortic stenosis and regurgitation, it is appropriate to riefly review the data on replacement of dysfunctional ortic prosthetic devices. Rossiter et al. reported 109 ortic valve reoperations with an operative mortailty f 14 percent (15 of 109) and a late mortality of 25 ercent (23 of 94).[55] They found that preoperative ardiac functional status and the nature of the athology mandating valve replacement were the prinipal determinants of both early and late mortality. atients with prosthetic endocarditis or stenosis contituted higher-risk subpopulations. Cohn et al. reorted 27 patients who underwent repeat surgery (8 or endocarditis, 10 for primary valve dysfunction, and for perivalvular leak) with an operative mortality of 5 percent (4 of 27) compared with 5.2 percent for nitial aortic valve replacement.[56] They concluded that he inhospital risk for replacement of a prosthetic valve vas not different from that of primary replacement nless the patient deteriorated to class IV and required mergency surgery.

The left ventricular response to the volume overload mposed by chronic aortic regurgitation has been reiewed by Ross.[35] It is characterized by the developnent of eccentric left ventricular hypertrophy. The left entricle can maintain a large ejection fraction without large increase in the left ventricular end-diastolic ressure due to the gradual increase in left ventricular iastolic compliance, the reduced afterload due to hronic peripheral vasodilatation, and the developnent of appropriate ventricular hypertrophy. The iastolic pressure-volume relation shifts to the right Figure 2). When myocardial contractility decreases, he end-systolic volume-wall stress relation shifts ownward to the right. At that time, irreversible nyocardial damage is present. Following successful urgery prior to the onset of irreversible damage, Kumuris et al. found complete normalization of endystolic dimension and of mean- and end-systolic wall tresses with persistence of a normal shortening fracion.[57] Their study supported the observations of Henry et al. and reinforced the need for surgical intervention prior to the onset of left ventricular deterioration.

MITRAL REGURGITATION

In comparison with the data accumulated for aortic valve replacement in aortic regurgitation, there is a paucity of comparable surgical data for mitral replacement in mitral regurgitation. This is due in part to the long latent period which characterizes the natural history of the disease. Also, early operative mortality figures were even less favorable than those for aortic regurgitation. Recently, improved surgical techniques and understanding of the pathophysiology of the lesion have led to improved operative mortality. Phillips et al. recently reported on 105 patients who underwent mitral valve replacement for isolated mitral regurgitation between 1974 and 1979 with 4 percent inhospital deaths.[58] In certain groups of patients it is possible to repair rather than replace the mitral valve. Kay et al. performed 133 consecutive mitral repairs for pure mitral regurgitation with an operative mortality of 5 percent.[59] Carpentier et al. reported 10 years' experience (1969 to 1978) with mitral reconstruction with an inhospital mortality of 4.2 percent in patients undergoing mitral repair only.[60] In a preliminary report, Boncheck had 1 operative death in 9 consecutive patients undergoing insertion of a prosthetic ring.[61]

The results of several series are presented in Table 1. Hammermeister et al. found borderline improvement over medical treatment with surgical treatment for mitral regurgitation.[30] They reported 70 percent 5-year survival in a 61-patient operative group versus 54 percent 5-year survival in the nonoperative group. Phillips et al. had an actuarially predicted 82 percent 5-year survival among 105 patients with mitral valve replacement.[58] Only age above 60 years and a preoperative ejection fraction less than 40 percent were found to correlate with a decreased 5-year survival. The data of Phillips et al. are compared to composite data for the natural history of the disease in Figure 5.

The indications for surgery in mitral regurgitation are summarized in Table 2. Surgery is indicated in symptomatic patients for symptomatic relief and preservation of left ventricular function when standard medical management is not successful. It should be emphasized again that mitral regurgitation is not necessarily progressive and that moderate-to-severe disease can be tolerated for many years without ill effects. Bonchek recommends surgery for symptoms alone in class III patients.[32] Class II patients who are content with their exercise capacity should be followed with chest x-rays at six-month intervals. If cardiac enlargement is noted, the chest x-ray should be repeated after three months. Progressive deterioration requires further noninvasive and subsequent invasion investigation. Ross recommends that cardiac catheterization should be performed when asymptomatic patients demonstrate left ventricular end-diastolic diameter approaching 80 mm, end-systolic diameter greater than 50 mm, fractional shortening less than 30 percent, or ejection fraction less than 55 percent.[35]

Mitral valve repair utilizing a prosthetic ring often is possible in nonrheumatic mitral regurgitation. This procedure avoids the complications of prosthetic dysfunction and the need for chronic anticoagulation. Furthermore, there is some preliminary data to suggest that hemodynamic function is preserved to a greater extent than with valve replacement.[61] However, mitral valve replacement remains the procedure of choice in rheumatic mitral regurgitation as well as those nonrheumatic cases where repair is not feasible.

The data on replacement of dysfunctional prosthetic mitral valves suggest that this can be performed without increased risk provided that the patient has not deteriorated to class IV or requires an emergency operation. Rossiter et al. reported 123 mitral reoperations with an early mortality of 10 percent (12 of 123) and a late mortality of 16 percent (18 of 111)[55]. Cohn et al. reported 31 mitral replacements (6 for endocarditis, 19 for primary valve dysfunction, and 6 for perivalvular leak) with 13 percent operative mortality (4 of 13) compared with 6.4 percent for initial mitral valve replacement.[56]

Unlike the increased left ventricular function commonly seen after aortic valve replacement for aortic regurgitation, left ventricular function usually deteriorates further after mitral valve replacement for mitral regurgitation. Patients with aortic regurgitation tend to tolerate larger left ventricular end-systolic volumes than those with mitral regurgitation. The explanation for these findings has its roots in the mechanisms by which the left ventricle compensates for volume overloading in mitral regurgitation. This subject has been reviewed in detail by Ross.[57]

There is an increase in left ventricular end-diastolic compliance as the left ventricle enlarges. The increase in end-diastolic volume and fiber length permit the left ventricle to eject a large stroke volume via the Frank-Starling mechanism (Figure 2). The left ventricle is protected from developing increased end-diastolic pressure or wall stress by the afterload reduction of the valvular lesion: the regurgitant fraction is ejected into the highly compliant, low pressure left atrium. Since there is no isovolumetric contraction, the energy of contraction can be expended in useful shortening rather than the development of wall tension. There is no decrease in coronary artery perfusion as sometimes occurs in aortic regurgitation. As with aortic regurgitation, the wall stress-volume relation shifts to the right with the development of eccentric hypertrophy. High stroke volume is maintained, mean wall stress decreases, and the ejection fraction may be supernormal. With decreased contractility, the curves shift downward and to the right. When the low impedance mitral leak is corrected surgically, the left ventricle must suddenly deliver the full stroke volume in the high-impedance aorta. The hidden myocardial damage is suddenly unmasked and the ejection fraction declines.

The effects of mitral valve replacement on the anatomy and physiology of the left ventricle are still incompletely understood. One study has shown that myocyte disarray develops in papillary muscles released from their attachments after mitral valve replacement.[62] This type of disarray was not thought to occur postnatally. Another study identified transverse midventricular disruption as the etiology of ver tricular rupture following placement of a Hancoc porcine prosthesis.[33] The authors speculated that th release of papillary muscles from their attachment weakened the anatomical support of the mi ventricular region leading to subsequent ruptur Twenty years ago, Lillehie et al. suggested that th disruption of papillary muscles with surgery was r sponsible for the subsequent left ventricular enlarg ment after mitral valve replacement.[63] This hypothesi was thought to have been disproved by Rastelli et a who studied canine mitral valve replacement with an without preservation of chordae tendineae and foun their presence or absence irrelevant to cardiac pe formance.[64] However, the preliminary report preserved hemodynamic function following mitra valve repair by Bonchek suggests that the canine ex periments may not have been pertinent.[61]

REFERENCES

1. Harken DE, Soroff HS, Taylor WJ, Lafemine AA, Gupt SK, Lunzer S: Partial and complete prostheses in aortic insu ficiency. *J Thorac Cardiovasc Surg* 40:744-762, 1960.
2. Starr A, Edwards ML: Mitral replacement: Clinical e perience with a ball-valve prosthesis. *Ann Surg* 154:726-74 1961.
3. Kirklin JW, Pacifico AD: Surgery for acquired valvula heart disease. *N Engl J Med* 288:133-140; 194-199, 1973.
4. Rahimtoola SH: Early valve replacement for the prese vation of function. *Am J Cardiol* 40:472-474, 1977.
5. Hammermeister KE: Chronic valvular disease i adults—when to operate. *J Cardiovasc Med* 6:632-655, 198
6. Rahimtoola SH: Valve replacement should not be pe formed in all asymptomatic patients with severe aortic in competence. *J Thorac Cardiovasc Surg* 79:163-172, 1980.
7. Rapaport E: Natural history of aortic and mitral valv disease. *Am J Cardiol* 35:221-227, 1975.
8. Bogart DB, Murphy BL, Wong BYS, Pugh DM, Dunn M Progression of aortic stenosis. *Chest* 76:391-396, 1979.
9. Cheitlin MD, Gertz EW, Brundage BH, Calson CJ, Quas JA, Bode RS: Rate of progression of severity of valvular aorti stenosis in the adult. *Am Heart J* 98:689-700, 1979.
10. Wagner S, Selzer A: Patterns of progression of aorti stenosis: A longitudinal hemodynamic study. *Circulatio* 65:709-712, 1982.
11. Ross J Jr, Braunwald E: Aortic stenosis. *Circulatio* 38:suppl V:V61-V67, 1968.
12. Bergeren J, Abelman WH, Vazquez-Milan H, Ellis LE Aortic stenosis-clinical manifestations and course of the dis ease. *Arch Intern Med* 94:911-924, 1954.
13. Wood P: Aortic stenosis. *Am J Cardiol* 1:553-571, 1958
14. Takeda J, Warren R, Holzman D: Prognosis of aorti stenosis. *Arch Surg* 87:931-963, 1963.
15. Rotman M, Morris JJ Jr., Behar VS, Peter RH, Kong Y Aortic valvular disease. *Am J Med* 51:241-257, 1971.
16. Frank S, Johnson A, Ross J Jr.: Natural history o valvular aortic stenosis. *Br Heart J* 35:41-46, 1973.
17. Schwarz F, Bauman P, Manthey J, Hoffman M, Schula G, Mehmel H, Schmitz W, Kubler W: The effect of aortic valv replacement on survival. *Circulation* 66:1105-1110, 1982.
18. Selzer A, Cohn KE: Natural history of mitral stenosis A review. *Circulation* 45:878-890, 1972.
19. Matthews MB, Medd WE, Gorlin R: Aortic stenosis: A clinical study. *Br Med J* 2:759-763, 1955.
20. Rowe JC, Bland EF, Sprague HB, White PD: The cours of mitral stenosis without surgery: Ten- and 20-year per spectives. *Ann Intern Med* 52:741-749, 1960.
21. Olesen KH: The natural history of 271 patients wit mitral stenosis under medical treatment. *Br Heart* 24:349-357, 1962.
22. Roy SB, Gopinath N: Mitral stenosis. *Circulatio* 38:suppl V:V68-V76, 1968.
23. Munoz S, Gallardo J, Diaz-Gorrin JR, Medina O: In fluence of surgery on the natural history of rheumatic mitra

id aortic valve disease. *Am J Cardiol* 35:234-242, 1975.
24. Goldschlager N, Pfeifer J, Cohn K, Popper R, Selzer A: ne natural history of aortic regurgitation. *Am J Med* :577-588, 1973.
25. Spagnuolo M, Kloth H, Taranta A, Doyle E, Pasternack Natural history of aortic regurgitation. *Circulation* :368-380, 1971.
26. Bland EF, Wheeler EO: Severe aortic regurgitation in ung people. *N Engl J Med* 256:667-672, 1957.
27. Waller BF, Morrow AG, Maron BJ, Del Negro AA, Kent M, McGrath FJ, Wallace RB, McIntosh CL, Roberts WC: iology of clinically isolated, severe, chronic, pure mitral re-rgitation: Analysis of 97 patients over 30 years of age ving mitral valve replacement. *Am Heart J* 104:276-288, 982.
28. Selzer A, Katayama F: Mitral regurgitation: Clinical pat-rns, pathophysiology, and natural history. *Medicine* :337-366, 1972.
29. Wilson MG, Lim WN: The natural history of rheumatic art disease in the third, fourth, and fifth decades of life. *rculation* 16:700-712, 1957.
30. Hammermeister KE, Fisher L, Kennedy JW, Samuels S, dge HT: Prediction of late survival in patients with mitral lve disease from clinical, hemodynamic, and quantitative giographic variables. *Circulation* 57:341-349, 1978.
31. Rahimtoola SH: Valvular heart disease: A perspective. *Am Coll Cardiol* 1:199-215.
32. Bonchek LI: Indications for surgery of the mitral valve. *n J Cardiol* 46:155-158, 1980.
33. Cobbs BW Jr., Hatcher CR Jr., Craver JM, Jones EL, well CW: Transverse midventricular disruption after mitral lve replacement. *Am Heart J* 99:33-50, 1980.
34. Smith N, McAnulty JH, Rahimtoola SH: Severe aortic enosis with impaired left ventricular function and clinical art failure: Results of valve replacement. *Circulation* :255-264, 1978.
35. Ross J Jr.: Left ventricular function and the timing of rgical treatment in valvular heart disease. *Ann Intern Med* : 498-504, 1981.
36. Canepa-Anson R, Emanuel RW: Elective aortic and itral valve surgery in patients over 70 years of age. *Br Heart* 41:493-497, 1979.
37. St. John Sutton MG, St. John Sutton M, Oldershaw P, acchetti R, Paneth M, Lennox SC, Gibson DG:Valve replace-ent without preoperative cardiac catheterization. *N Engl J ed* 305:1233-1238, 1981.
38. Brandenburg RO: No more routine catheterization for lvular disease. *N Engl J Med* 305:1277-1278, 1981.
39. Hakki A, Kimbiris D, Iskandrian AS, Segal BL, Mintz S, Benis CE: Angina pectoris and coronary artery disease patients with severe aortic valvular disease. *Am Heart J* 00:441-449, 1980.
40. O'Rourke RA: Preoperative cardiac catheterization: Its ed in most patients with valvular heart disease. *JAMA* 8:745-750, 1982.
41. Rahimtoola SH: The need for cardiac catheterization d angiography in valvular heart disease is not disproven. *n Intern Med* 97:433-439, 1982.
42. Wisoff G, Fogel R, Weisz D, Garvey J, Hamby R: Com-ned valve and coronary artery surgery. *Ann Thorac Surg* :440-443, 1979.
43. Carabello BA, Green LH, Grossman W, Cohn LH, Koster , Collins JJ: Hemodynamic determinants of prognosis of rtic valve replacement in critical aortic stenosis and ad-nced congestive heart failure. *Circulation* 62:42-48, 1980.
44. Rutledge R, McIntosh CL, Morrow AG, Picken CA, Siwek G, Zwischenberger JB, Schier JJ: Mitral valve replacement er closed mitral commissurotomy. *Circulation* 66:suppl 162-I166, 1982.
45. Gross RI, Cunningham JN Jr, Snively SL, Catinella FP, than IM, Adams PX, Spencer FC: Long-term results of open dical mitral commissurotomy: Ten-year followup study of 202 patients. *Am J Cardiol* 47:821-825, 1981.
46. Bonchek LI: Mitral valve replacement with cloth-covered composite-seat prostheses: The case for early operation. *J Thorac Cardiovasc Surg* 67:93-109, 1974.
47. Flessas AP, Ryan TJ: Cardiovascular responses to isometric exercise in patients with mitral stenosis. *Arch Intern Med* 142:1629-1633, 1982.
48. Wroblewski E, James F, Spann JF, Bove AA: Right ventricular performance in mitral stenosis. *Am J Cardiol* 47:51-55, 1981.
49. Ward C, Hancock BW: Extreme pulmonary hypertension caused by mitral valve disease: Natural history and results of surgery. *Br Heart J* 37:74-78, 1975.
50. Dalby AJ, Firth BG, Forman R: Preoperative factors affecting the outcome of isolated mitral valve replacement: A 10-year review. *Am J Cardiol* 47:826-834, 1981.
51. Greves J, Rahimtoola SH, McAnulty JH, DeMots H, Clark DG, Greenberg B, Starr A: Preoperative criteria predictive late survival following valve replacement for severe aortic regurgitation. *Am Heart J* 101:300-308, 1981.
52. Henry WL, Bonow RO, Borer JS, Ware JH, Kent KM, Redwood DR, McIntosh CL, Morrow AG, Epstein SE: Observations on the optimum time for operative intervention for aortic regurgitation. I. Evaluation of the results of aortic valve replacement in symptomatic patients. *Circulation* 61:471-492, 1980.
53. O'Rourke RA, Crawford MH: Editorial: Timing of valve replacement in patients with chronic aortic regurgitation. *Circulation* 61:493-495, 1980.
54. Bonow RO, Rosing DR, Kent KM, Epstein SE: Timing of operation for chronic aortic regurgitation. *Am J Cardiol* 50:325-336, 1982.
55. Rossiter SJ, Miller DC, Stinson EB, Oyer PE, Reitz BA, Shumway NE: Aortic and mitral prosthetic valve reoperations. *Arch Surg* 114:1279-1283, 1979.
56. Cohn LH, Koster JK Jr, VandeVanter S, Collins JJ: The inhospital risk of rereplacement of dysfunctional mitral and aortic valves. *Circulation* 66:suppl I:I153-I156, 1982.
57. Kumpuris AG, Quinones MA, Waggoner AD, Kanon DJ, Nelson JG, Miller RR: Importance of preoperative hypertrophy, wall stress, and end-systolic dimension as echocardiographic predictors of normalization of left ventricular dilatation after valve replacement in chronic aortic insufficiency. *Am J Cardiol* 49:1091-1100, 1982.
58. Phillips HR, Levine FH, Carter JE, Boucher CA, Osbakken MD, Okada RD, Akins CW, Daggett WM, Buckley MJ, Pohost GM: Mitral valve replacement for isolated mitral regurgitation: Analysis of clinical course and later postoperative left ventricular ejection fraction. *Am J Cardiol* 48:647-654, 1981.
59. Kay JH, Zubiate P, Mendez AM, Carpena C, Watanabe K, Magidson O: Mitral valve repair for patients with pure mitral insufficiency. *JAMA* 236:1584-1586, 1976.
60. Carpentier A, Chauvaud S, Fabiani JN, Deloche A, Relland J, Lessana A, d'Allaines CL, Blondeau PH, Piwnica A, Dubost CH: Reconstructive surgery of mitral valve incompetence: Ten-year appraisal. *J Thorac Cardiovasc Surg* 79:338-348, 1980.
61. Bonchek LI: Correction of mitral valve disease without valve replacement. *Am Heart J* 104:865-868, 1982.
62. Pirolo JS, Hutchins GM, Moore GW, Weisfeldt ML: Myocyte disarray develops in papillary muscles released from normal tension after mitral valve replacement. *Circulation* 66:841-846, 1982.
63. Lillehie CW, Levy MJ, Bonnabear RC: Mitral valve replacement with preservation of papillary muscles and chordae tendineae. *J Thorac Cardiovasc Surg* 47:532-543, 1964.
64. Rastelli GC, Tsakiris AG, Frye RL, Kirklin JW: Exercise tolerance and hemodynamic studies after replacement of canine mitral value with and without preservation of chordae tendineae. *Circulation* 34:suppl I:I34-141, 1967.

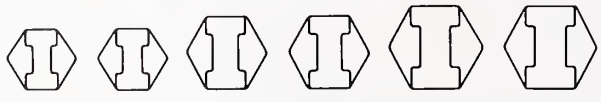



"When the Ayerst rep told me
it costs about 45¢ a day,
I said you can stop right there."
Most doctors are pleasantly surprised to learn that the average cost of daily therapy with the world's most widely used beta blocker is so little, not much more than the cost of a daily newspaper.
When it's INDERAL tablets (propranolol hydrochloride) you want for your hypertension patients, remember to specify Dispense As Written (DAW) or Do Not Substitute on your prescriptions. That way, you can always be assured they'll get INDERAL®.
Please see next page for brief summary of prescribing information.
INDERAL®
(PROPRANOLOL HCl)
Small price to pay.

"When the Ayerst rep told me it costs about 45¢ a day, I said you can stop right there."

INDERAL® TABLETS

(PROPRANOLOL HCl)



10 mg 20 mg 40 mg 60 mg 80 mg 90 mg*

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

INDERAL® (propranolol hydrochloride) Tablets

CLINICAL PHARMACOLOGY

The Beta-Blocker Heart Attack Trial (BHAT) was a National Heart, Lung and Blood Institute-sponsored multicenter, randomized, double-blind placebo-controlled trial conducted in 31 U.S. centers (plus one in Canada) in 3,837 persons without history of severe congestive heart failure or presence of recent heart failure; certain conduction defects; angina since infarction, who had survived the acute phase of myocardial infarction. Propranolol was administered at either 60 or 80 mg t.i.d. based on blood levels achieved during an initial trial of 40 mg t.i.d. Therapy with INDERAL, begun 5-21 days following infarction, was shown to reduce overall mortality up to 39 months, the longest period of follow-up. This was primarily attributable to a reduction in cardiovascular mortality. The protective effect of INDERAL was consistent regardless of age, sex or site of infarction. Compared to placebo, total mortality was reduced 39% at 12 months and 26% over an average follow-up period of 25 months. The Norwegian Multicenter Trial in which propranolol was administered at 40 mg q.i.d. gave overall results which support the findings in the BHAT.

Although the clinical trials used either t.i.d. or q.i.d. dosing, clinical, pharmacologic and pharmacokinetic data provide a reasonable basis for concluding that b.i.d. dosing with propranolol should be adequate in the treatment of post-infarction patients.

CLINICAL: In the BHAT, patients on INDERAL were prescribed either 180 mg/day (82% of patients) or 240 mg/day (18% of patients). Patients were instructed to take the medication 3 times a day at mealtimes. This dosing schedule would result in an overnight dosing interval of 12 to 14 hours which is similar to the dosing interval for a b.i.d. regimen. In addition, blood samples were drawn at various times and analyzed for propranolol. When the patients were grouped into tertiles based on the blood levels observed and the mortality in the upper and lower tertiles were compared, there was no evidence that blood levels affected mortality.

PHARMACOLOGIC: Studies in normal volunteers have shown that a 90 mg b.i.d. regimen maintains beta blockade at, or above, the minimum for 60 mg t.i.d. dosing for 24 hours even though differences occurred at two time intervals. At 10-12 hours after the first dose of the day, t.i.d. dosing gave more beta blockade than b.i.d. dosing; at 20-24 hours the trend of the relationship was reversed. These relationships were similar in direction to those observed for plasma propranolol levels (see Pharmacokinetic).

PHARMACOKINETIC: A bioavailability study in normal volunteers showed that the blood levels produced by 180 mg/day given b.i.d. are below those provided by the same daily dosage given t.i.d. at 10-12 hours after the first dose of the day but above those of a t.i.d. regimen at 20-24 hours. However, the blood levels produced by b.i.d. dosing were always equivalent to or above the minimum for t.i.d. dosing throughout the 24 hours. In addition, the mean AUC on the fourth day for the b.i.d. regimen was about 17% greater than for the t.i.d. regimen (1,194 vs. 1,024 ng/ml• hr).

CONTRAINDICATIONS

INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS

CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS.

INDERAL (propranolol hydrochloride) should be administered with caution since it may ... bronchodilation produced by endogenous and exogenous catecholamine stimulation o... receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therap... prior to major surgery is controversial. It should be noted, however, that the impaired abi... the heart to respond to reflex adrenergic stimuli may augment the risks of general anesth... and surgical procedures.

INDERAL, like other beta blockers, is a competitive inhibitor of beta-receptor agonists ... its effects can be reversed by administration of such agents, e.g., dobutamine or isopro... terenol. However, such patients may be subject to protracted severe hypotension. Diffic... starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appea... ance of certain premonitory signs and symptoms (pulse rate and pressure changes) of a... hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more diff... to adjust the dosage of insulin.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Th... fore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms ... hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function te...

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have bee... reported in which, after propranolol, the tachycardia was replaced by a severe bradycar... requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg ... propranolol.

PRECAUTIONS

General: Propranolol should be used with caution in patients with impaired hepatic or re... function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients ... should be told that INDERAL may interfere with the glaucoma screening test. Withdrawa... lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart dise... elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as re... pine should be closely observed if INDERAL is administered. The added catecholamine ... blocking action may produce an excessive reduction of resting sympathetic nervous ac... which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orth... static hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility. Long-term studies in animals ha... been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studie... both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of sig... cant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the ... age levels. Reproductive studies in animals did not show any impairment of fertility that ... attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in a ... studies at doses about 10 times greater than the maximum recommended human dose. ... There are no adequate and well-controlled studies in pregnant women. INDERAL shou... be used during pregnancy only if the potential benefit justifies the potential risk to the fet...

Nursing Mothers. INDERAL is excreted in human milk. Caution should be exercised wi... INDERAL is administered to a nursing woman.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Most adverse effects have been mild and transient and have rarely required the withdraw... therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block, hyp... sion; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of th... Raynaud type.

Central Nervous System: Lightheadedness, mental depression manifested by insomn... lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visi... disturbances; hallucinations; an acute reversible syndrome characterized by disorientat... for time and place, short-term memory loss, emotional lability, slightly clouded sensorium ... and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, ... constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with ac... and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic ... purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been ... reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impo... tence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reaction ... involving the skin, serous membranes and conjunctivae reported for a beta blocker (pra... lol) have not been associated with propranolol.

*The appearance of INDERAL tablets is a registered trademark of Ayerst Laboratories.

9371/1184

Ayerst® AYERST LABORATORIES
New York, N.Y. 10017

Dialysis for End-Stage Renal Disease

John A. Walker, M.D., Robert Dodelson, M.D., Robert P. Eisinger, M.D. New Brunswick*

As a consequence of end-stage renal disease, approximately 60,000 persons in the U.S. are dependent upon chronic dialysis.[1] These people receive care from non-nephrologists who may not be familiar entirely with the various dialytic modalities and special needs of this population.

In 1854, Thomas Graham, a Scottish chemist, used the term dialysis (from the Greek dialyo, separate) to describe the movement of various utes across a semipermeable membrane.[2] In 1918, s concept was applied in vivo by Abel and his co-rkers. They demonstrated the removal of nonprotein rogen from the blood of a dog by passing the imal's anticoagulated blood through a series of loidin tubes contained within a saline-filled glass ket.[3] Their device bears a striking resemblance to hollow-fiber dialyzers used today.

n 1926, the first human hemodialysis was per-med in Germany by Haas. However, it was not until 45 that Kolff performed the first hemodialysis that stained a patient suffering from acute renal failure til recovery ensued.[2]

Technical refinements of the hemodialysis tech-que included the development of more efficient lyzing membranes and incorporation of the mem-ne into smaller containers. However, hemodialysis nained available only to those with reversible renal ure as there was no way of gaining repeated, long-m access to the circulation.

n 1960, Quinton and colleagues developed an ex-nal arteriovenous shunt. Permanently placed into vasculature, this device allowed repeated access to circulation.[4] Thus, the goal of chronic hemodialysis the patient with irreversible renal failure was realized. The cost of chronic hemodialysis remained a formidable obstacle until 1972, when passage of Public Law 92-603 extended Medicare coverage to all patients with end-stage renal disease.[5]

PREDIALYSIS MANAGEMENT

Most individuals with advanced chronic renal failure, regardless of etiology, exhibit a steady decline in renal function until dialysis is necessary to avoid or reverse uremia. The nature of this decline and modulating therapies are the subject of intensive investigation.[6,7]

It is not the purpose of this article to review the management of the patient with chronic renal failure. However, several important steps should be taken once an individual with irreversible renal failure is identified. The patient should be informed of the eventual need for dialysis and the various dialytic modalities available. Consultation with a nephrologist may be desirable at this time, since all modalities are not suitable for all patients. In appropriate settings, renal transplantation may be offered as the initial treatment for end-stage renal disease or as an option to be con-

*From the Department of Medicine, Division of Nephrology, UMDNJ-Rutgers Medical School, New Brunswick. Correspondence may be addressed to Dr. Walker, UMDNJ-Rutgers Medical School, Academic Health Science Center, CN 19, New Brunswick, NJ 08903.

sidered once dialysis is established. In any event, such a presentation allows decisions to be made in a relatively unhurried fashion. Delaying a discussion of dialysis until the patient is nearly uremic or overtly uremic is of no benefit.

If hemodialysis is deemed appropriate, vascular access should be established prior to initiating chronic hemodialysis. The arteriovenous fistula, developed by Brescia and Cimino in the mid-1960s, presently is the preferred technique.[8] A subcutaneous arteriovenous (AV) anastomosis is created surgically, typically in the nondominant upper extremity. In a few weeks to months, the diverted arterial flow "arterializes" the venous system, creating a network of hypertrophied vessels that can withstand multiple needle punctures and provide optimal blood flow. If the native vasculature cannot support an AV fistula (as may be the case in diabetic or elderly individuals), a synthetic or bovine graft may be anastomosed into the extremity's blood vessels. In either case, the access should be established by an experienced vascular surgeon.

The existence of a healed, mature vascular access greatly facilitates the initiation of chronic hemodialysis and avoids the need for femoral vessel cannulation or subclavian vein catheterization. Since the AV fistula is a high-flow, high-pressure system, it must not be subjected to sphygmomanometry or routine venipuncture.

When to initiate chronic dialysis depends upon a combination of clinical and laboratory data.[9] Few would argue that dialysis ought to begin when the creatinine clearance (Ccr) falls below 5 ml/min, even if the patient feels reasonably well. Uremic symptoms are not reversed readily by dialysis and there is little to be gained by temporizing for another month or two at the risk of developing uremic bleeding, hyperkalemia, pericarditis, or neuropathy. At Ccrs of 10 to 5 ml/min, the patient should be monitored for any vague constitutional symptoms such as anorexia, weakness, or pruritus which may be manifestations of uremia. Such individuals often note a remarkable improvement in their sense of well-being after initiation of dialysis. By this time, the primary physician and the patient should have established a relationship with a nephrologist who will be able to assist in deciding when to begin dialysis.

For a more extensive discussion of the management of the predialysis patient, the reader is referred to recent reviews.[10,11]

HEMODIALYSIS—PRINCIPLES

Dialysis can accomplish two objectives: 1) the removal of excess solutes that accumulate in the body as a result of their diminished excretion; and 2) the removal of water that accumulates as a consequence of the end-stage kidney's inability to generate free water. Although the kidney's role as a hormonal organ is well established, resultant derangements from end-stage renal disease are not directly ameliorated by chronic dialysis.

Regardless of the hardware employed, the basic principles of hemodialysis are the same. Blood is withdrawn into an extracorporeal circuit where, via a roller pump, it is passed across a synthetic, semipermeable membrane. This membrane separates the blood from the dialysate, a solution with a composition that, with certain exceptions, approximates plasma water. A typical dialysate contains sodium, chloride, magnesium, and calcium in concentrations equal to or slightly less than that of normal plasma. Potassium may be added to a concentration of 2 to 3 mEq/l. Dextrose may be added to prevent hypoglycemia and facilitate water removal. Acetate replaces bicarbonate as a buffer, since the latter would precipitate calcium and magnesium in the commercially prepared solutions. Recent data suggest acetate may have deleterious effects on the cardiovascular system during hemodialysis, and dialysis machines now are available that mix bicarbonate into a buffer-free dialysate just before the solution reaches the membrane.[12]

The synthetic dialysis membrane commonly is manufactured from regenerated cellulose. Noncellulosic membranes, e.g. polyacrylonitrile, also are available.[13] These newer materials can effect greater clearances of larger molecules, theoretically an advantage if middle molecules are indeed responsible for abnormalities that persist in spite of chronic hemodialysis. The membrane is packaged in a container that has inlet and outlet ports for both blood and dialysate. This unit is referred to as the dialyzer.

Most present-day dialyzers utilize a membrane arranged to form either a bundle of hollow fibers with internal diameters of 200 to 300 μM or a series of parallel plates. Both are enclosed within a rigid container and are noncompliant. This noncompliance permits the removal of water from the plasma by applying negative hydrostatic pressure to the dialysate side of the membrane.

The dialysis machine delivers blood and dialysate to the dialyzer at appropriate rates. Once the blood and dialysate come into contact with the membrane, solutes begin moving across the membrane down their concentration gradients. In this fashion, undesirable solutes such as urea and creatinine are removed from the plasma.

Most dialysis machines in use today are single-pass proportioning systems. That is, the dialysate makes a single pass across the membrane, countercurrent to blood flow, and then is discarded. The average dialysate flow rate is 500 ml/min. To avoid the need for storing the 120 liters of dialysate required for a four-hour treatment, the machine proportions a dialysate concentrate into treated tap water at a 1:35 ratio. The machine monitors the dialysate for proper temperature and electrical conductivity (the latter is a measurement of proper proportioning function). The machine also measures pressures within the extracorporeal blood circuit and monitors for air leaks within the blood lines. These features are incorporated in a compact machine with automatic monitoring and shut-off functions, thus making home hemodialysis a practical option for many patients.

Another type of dialysis machine regenerates used dialysate by passing it through a cartridge containing urease, ion exchange resins, and activated charcoal. The regenerated dialysate then can be passed through the dialyzer again. This system requires only 5.5 liters of dialysate and thus is not dependent upon a continuous water supply. However, dialysis with this system results in changes in serum chemistries that are some

hat different from those seen with single-pass sys-
ms. It is not in widespread use.[14]

The removal of excess water is accomplished as
ater is separated from the protein and cellular ele-
ents of the blood, a process known as ultrafiltration.
uring hemodialysis, ultrafiltration is achieved largely
applying appropriate hydrostatic pressure to one
de of the membrane. In single-pass systems utilizing
oncompliant dialyzers, the application of negative
drostatic pressure to the dialysate circuit results in
t fluid removal from the plasma water. How much
uid must be removed is determined by the difference
tween a patient's weight at the beginning of a
alysis treatment and that individual's dry weight.
ie dry weight is the weight at which the patient is
nically euvolemic and usually normotensive. By
owing the ultrafiltration properties of the particular
alyzer being used, the dialysis staff can adjust the
achine to ultrafilter the volume of water necessary
achieve dry weight at the treatment's conclusion.
Ultrafiltration also may be effected by using osmotic
ther than hydrostatic forces. This principle is em-
oyed in peritoneal dialysis.

HE DIALYSIS REGIMEN

The usual hemodialysis "prescription" consists of 4
5 hours of dialysis administered thrice weekly. For
ost patients, this leads to resolution of many of the
emic symptoms that may have been present prior to
itiation of dialysis. Twelve to 15 hours of
modialysis weekly also maintain urea nitrogen levels
thin an acceptable range. Unfortunately, chronic
modialysis does not resolve all features of end-stage
nal disease. Some degree of anemia persists in most
tients. Moreover, problems such as osteodystrophy
d neuropathy may progress in spite of regular
alysis. That these problems may ameliorate after a
ccessful renal transplant is evidence that the
alysis regimen does not completely replace normal
nal function.[15,16]

Chronic dialysis affords increased longevity to the majority of patients with end-stage renal disease.

The excretion of various solutes by the kidney com-
only is expressed in terms of clearance. The method
which the kidney clears solutes from the plasma is
ite different from that seen with dialyzing mem-
anes. This is evident when the clearances of two
lutes of different molecular size are compared. The
earances of creatinine (113 daltons) and inulin
200 daltons) by the normal kidney are nearly iden-
al (approximately 100 ml/min). Yet, when dialyzer
earances of these substances are measured, the
earance of inulin is much less than that of creatinine
ml/min *v* 90 ml/min, respectively). Thus, the
alyzer clears small molecules such as urea and
eatinine rapidly, and clearances of these solutes may
improved by increasing blood flow rates across the
embrane. However, dialyzer clearances of molecules larger than 500 daltons are low. The clearance of molecules in this middle range (500 to 5,000 daltons) may be improved somewhat by increasing the duration of dialysis and/or increasing the surface area of the dialyzing membrane.[17]

These observations are explained by the fact that solute clearance across the dialyzing membrane is governed by the relatively small pore size of the membrane and the varying sizes of plasma solutes. Small molecules easily pass through the membrane pores; larger molecules diffuse across the membrane with greater difficulty as their molecular sizes increase. It has been proposed that the persistence of some of the complications of end-stage renal disease (anemia, neuropathy, and osteodystrophy) in spite of regular dialysis is due to an accumulation of these poorly cleared middle molecules.[18] A great deal of investigative activity has not yet identified which middle molecules might be uremic toxins.[19] Dialysis regimens have been modified in an effort to improve clearances of these solutes. However, a recent national cooperative study showed that when compared with patients whose BUN was allowed to remain high (90 mg/dl), chronic hemodialysis patients whose BUNs were kept low (50 mg/dl) required fewer hospitalizations regardless of whether they received 9 or 13½ hours of dialysis weekly.[20] These results tend to refute the middle molecule hypothesis, which would have predicted a better outcome for the patients who received longer treatments regardless of urea levels.

Presently, therefore, dialysis regimens are designed to maintain reasonable levels of measurable solutes and an acceptable state of fluid balance. For most patients, 12 to 15 hours of dialysis weekly appear adequate.

MEDICAL MANAGEMENT OF THE DIALYSIS PATIENT

Nearly all patients receiving chronic hemodialysis must adhere to certain dietary restrictions. It is difficult to ultrafilter large volumes in the course of a four-hour dialysis treatment without precipitating hypotension, syncope, or muscle cramps. Therefore, fluid intake must be closely monitored and limited if interdialytic fluid gains are excessive. Most patients are placed on sodium and potassium restrictions as well.

In contrast to the protein restriction often prescribed for predialysis azotemic patients, chronic hemodialysis patients are encouraged to consume a high-quality protein diet (1 gm/kg/day), since regular dialysis will maintain urea at acceptable levels. Unfortunately, this protein intake obligates a substantial phosphate intake. High phosphate levels generally are undesirable in the chronic hemodialysis patient, as they perpetuate the vicious cycle of secondary hyperparathyroidism and resultant osteodystrophy.[21] Accordingly, oral phosphate binders in the form of aluminum hydroxide or aluminum carbonate are administered. The constipation these agents may induce makes patient compliance difficult. Stool softeners or oral sorbitol may alleviate this problem, but occasionally a tap water or soap-suds enema is necessary. Under no circumstances should a dialysis patient re-

ceive a Fleet® enema or a magnesium-containing cathartic. The phosphate and magnesium loads these agents respectively contain clearly are dangerous to the individual with end-stage renal disease. Most patients take a daily water-soluble vitamin and folate supplement to replace dialysis losses.[22]

The excretion of many drugs and their metabolites is dependent upon normal renal function. Furthermore, some medications are removed efficiently by hemodialysis. These factors must be taken into account when prescribing medication for the chronic hemodialysis patient. Failure to do so may result in drug toxicity or subtherapeutic drug levels.[23] Dosing guidelines are available to aid the clinician in planning appropriate medication regimens.[24]

A detailed discussion of the medical complications associated with chronic hemodialysis is beyond the scope of this article. However, we will briefly discuss certain problems the non-nephrologist may encounter in the chronic hemodialysis patient.

Often referred to as the Achilles' heel of chronic hemodialysis, the vascular access may be the site of several complications.[25] Both grafts and native fistulas may become thrombosed or stenotic, resulting in diminished blood flow through the access network.[26] Such a complication may be heralded by loss of the thrill over the fistula. Prompt referral to a vascular surgeon is indicated, as thrombectomy or revision of the access will likely be necessary. As the vascular access is a high-flow, turbulent system, antibiotic prophylaxis is recommended for the chronic hemodialysis patient scheduled to undergo dental, upper respiratory, genitourinary, or gastrointestinal procedures.[27]

The vascular access always should be considered a source of an otherwise unexplained bacteremia, even when the access site clinically appears benign. Staphylococci are common organisms in this setting, and endocarditis may complicate the picture.[28] Appropriate antibiotic therapy alone may suffice when a native fistula is the source of infection, but infected synthetic or bovine grafts may have to be removed to effect a cure.[29]

That cardiovascular complications are common in the chronic hemodialysis population is not surprising, since many of these patients have a history of cardiovascular disease. Hypertension in the end-stage renal disease population usually is due to fluid overload. Normotension is achieved with fluid and salt restriction along with progressive ultrafiltration to the appropriate dry weight. However, a minority of patients remain hypertensive despite euvolemia and will require antihypertensive medication. Increased peripheral vascular resistance secondary to hyperreninemia has been shown to be responsible for many such cases.[30] In the past, bilateral nephrectomy was required to control blood pressure when pharmacologic therapy failed. The availability of newer agents such as captopril and minoxidil now largely render this procedure unnecessary.[31] Indeed, the "end-stage" kidney still may perform some degree of solute excretion and hormonal, e.g. erythropoietin, production, so preservation of renal parenchyma usually is desirable.

Hemodialysis may precipitate hypotension and arrhythmias in patients with ischemic heart disease. These problems may be aggravated if interdialytic fluid gains are excessive. In these fragile patients, adequa ultrafiltration rates may be achieved if the ultr filtration is performed without concomitant dialysis The anemia that accompanies end-stage renal disea may exacerbate angina. Such patients may requi periodic red blood cell transfusions to avoid sympt matic ischemia.

Pericarditis commonly is not observed once regul dialysis is well underway. However if, through a varie of circumstances, a patient is relatively underdialyze pericarditis may be the first overt manifestation uremia.[33] Patients receiving chronic hemodialysis m be at increased risk for viral infections, which may manifest as pericarditis.[34]

In spite of these problems, the presence cardiovascular disease could not be considered a absolute contraindication to hemodialysis. Many suc patients tolerate chronic hemodialysis without undu difficulty. It may be necessary to provide a trial hemodialysis before recommending another modalit

The majority of chronic hemodialysis patien exhibit a normocytic anemia. While diminishe erythropoietin production may play an etiologic rol erythropoietin levels have been noted to be normal even elevated in some patients.[35] Impaired bone ma row erythrogenesis and shortened red blood ce survival are demonstrable in end-stage renal diseas and these undoubtedly are important factors in th pathophysiology of the anemia.[36] Many patients tole ate hematocrits of 20 to 30 percent surprisingly we There usually is no need to administer blood tran fusions unless a patient becomes symptomatic. Th hematocrit often will increase once a patient is starte on chronic hemodialysis.[37] Furthermore, routir transfusions may lead to iron overload and hemo siderosis.[38,39] Patients may, however, develop iro deficiency due to small but ongoing blood losses ir curred with each treatment, since some red cells ir evitably are left behind in dialyzers and blood lines. Oral iron supplements therefore are given to most pa tients. Parenteral androgens often are helpful in mair taining adequate hemoglobin levels.[41] A number o studies have shown improved renal transplant surviva in patients who received red cell transfusions prior t the transplantation.[42] The reason for this is poorl understood, but most transplant centers now rec ommend that patients awaiting a cadaveric rena transplant receive several units of packed red cell before surgery.[43]

Many chronic hemodialysis patients have prolonged bleeding time due to a qualitative platele dysfunction. This may improve following dialysis.[44] I addition, administration of cryoprecipitate or ir travenous desmopressin may temporarily correct thi defect.[45,46]

Osteodystrophy remains a frustrating problem fo patients and physicians. Chronic hemodialysis pa tients may suffer from a variety of bone disorders including osteosclerosis, osteitis fibrosa cystica, an osteomalacia.[47] Attempts to suppress the high para thyroid hormone (PTH) levels seen in many patient by controlling serum phosphate and administerin oral calcium and vitamin D analogues may be onl partially successful. High PTH levels also have bee incriminated as an etiologic factor in the anemia an

uropathy of end-stage renal disease.[48,49] Parayroidectomy may be necessary in resistant cases. ecently, a group of chronic hemodialysis patients has en described with osteomalacia, increased bone uminum content, myopathy, and normal PTH vels.[50] In these patients trials of chelation therapy ith desferrioxamine to reduce aluminum stores presitly are in progress.[51]

The chronic hemodialysis population is at increased sk for infection. The cell-mediated immune response depressed.[52] This may in part explain the higher cidence of hepatitis B and mycobacterial infections en in these patients.[53,54] However, responses to imunization often are adequate.[55] Therefore, administation of pneumococcus, influenza, and, if hepatitis surface antibodies are not present, hepatitis B vacne is recommended.

Neurologic disorders may cause signficant problems the chronic hemodialysis patient. Uremic neupathies, both sensory and motor, may be arrested by ronic hemodialysis but improvement usually is oted only after a successful renal transplant.[16] ncephalopathy may indicate a central nervous sysm infection, subdural hematoma, or dialysis dementa.[56] The last is a syndrome peculiar to chronic emodialysis patients, often accompanied by dysraxia, myoclonus, and a characteristic electoencephalogram. Aluminium has been implicated as n etiologic factor, but the exact cause of this often tal disorder remains unknown.[57]

Chronic hemodialysis also may be associated with number of iatrogenic complications. Hemolysis may ccur if dialysate water contains high levels of copper chloramine.[58,59] Proper water treatment at the alysis unit usually will prevent this. Water-borne acterial contaminants may cause febrile reactions.[60] ecently, a review of liver biopsies obtained from CHD atients revealed areas of inflammation and fibrosis in hich silicone particles were found. The silicone resumably entered the circulation via spallation of licone blood tubing by the dialysis machine's roller ump.[61] Patients on chronic hemodialysis must be ancoagulated with heparin during each dialysis session prevent their blood from clotting within the dialyzer. his may increase the risk of bleeding if other athology is present (e.g. peptic ulcer disease).

ERITONEAL DIALYSIS

At present, only about 10 percent of the end-stage nal disease population is maintained on some form chronic peritoneal dialysis; there is considerable terest in this increasingly popular modality.[62]

The concept of utilizing the peritoneum as a dialyzg membrane dates back to the 1920s.[63] However, it as not until the 1970s that Moncrief and Popovich heorized that adequate dialysis could be achieved by equentially instilling and draining two liter aliquots dialysate into and out of the peritoneal cavity five mes daily.[64] This concept has evolved into the techique of continuous ambulatory peritoneal dialysis CAPD).

When compared with artificial dialyzers, the perioneum, in many respects, is less efficient. Peritoneal earances of small molecules such as urea and reatinine are substantially less than those achieved with hemodialysis membranes.[65] However, in CAPD the dialysate is almost constantly in contact with the peritoneum. Therefore, when calculated on a weekly basis, small molecular clearances nearly are equivalent in the two modalities. Furthermore, clearance of larger molecules actually is better in CAPD than with chronic hemodialysis. Nolph has explained these features with a model of the peritoneal membrane that incorporates a small number of large pores through which larger molecules may easily pass.[66]

Ultrafiltration in CAPD is accomplished via osmotic, rather than hydrostatic, forces. Peritoneal dialysate is rendered hypertonic to plasma by adding dextrose. Peritoneal instillation of this hypertonic solution causes plasma water to move out of the vascular space into the peritoneal cavity. This volume then is removed when the dialysate is drained.

Infection in the form of peritonitis remains the most common complication of CAPD.

The actual technique of CAPD is relatively simple. A permanent, flexible catheter is placed surgically in the peritoneal cavity. A short segment of this catheter remains external, and is attached to a connecting tube. At the end of the connecting tube is a spike connector. The dialysate is supplied in plastic bags. Two liter aliquots usually are employed. The spike connector is inserted into the dialysate bag and dialysate is instilled into the peritoneal cavity. When emptied, the bag and connecting tube are rolled up and tucked under the patient's clothing. The dialysate is allowed to dwell in the peritoneal cavity for approximately four hours. The bag then is unrolled and the dialysate is allowed to drain back into the bag. The bags are designed to accommodate the extra volume removed by ultrafiltration. When drainage is complete, the drained bag is discarded and a bag of fresh dialysate attached to the spike connection. The cycle then is repeated. The exchange of bags must be performed using sterile technique. Three exchanges are performed during the day. A fourth aliquot is instilled at bedtime and drained in the morning. In this fashion, adequate biochemical and volume control can be achieved.[67]

The exchange technique is taught to most patients, who then are able to perform their own dialysis. Although CAPD must be done daily, these patients are freed from the logistic and temporal restrictions of chronic hemodialysis. Patients who are employed must perform one exchange at the workplace. Traveling no longer is restricted, since the CAPD patient can pack the necessary quantity of dialysate and supplies. The exchanges can be performed wherever a small sterile field can be set up.

CAPD thus is an appropriate modality for the end-stage renal disease patient whose activities or employment would make adherence to a thrice weekly hemodialysis schedule difficult. Patients with a frail cardiovascular status also might be considered for CAPD, where ultrafiltration rates are slower, thus effecting a gentler control of volume. Diabetics with end-

stage renal disease may do well on CAPD. Regular insulin added to the dialysate often results in improved blood glucose control and dispenses with the need for subcutaneous insulin injections. However, total insulin requirements increase due to the added carbohydrate load of the dialysate dextrose.[68]

A history of multiple abdominal surgical procedures is a relative contraindication to CAPD. The presence of adhesions or peritoneal scarring may impair the efficacy of the dialysis. Abdominal ostomies usually are a contraindication to CAPD due to the increased risk of catheter infection, and abdominal or inguinal hernias should be repaired prior to initiating CAPD. Patients with a history of low back pain or lumbar disk disease have reported worsening of their symptoms with CAPD. CAPD may produce increased dyspnea in those with severe chronic lung disease, presumably due to the limitation of diaphragmatic mobility induced by the instillation of the large dialysate volumes.[69] Finally, successful CAPD requires a motivated, compliant patient who will perform the four daily exchanges using aseptic technique. If the patient is not able to perform the exchanges, a family member may be trained. However, in our opinion nonself-administered CAPD is an arrangement that should be approached with caution.

Infection in the form of peritonitis remains the most common complication of CAPD. Even in centers with a large CAPD population and long-term experience, infection rates average one to two episodes per patient year.[67]

Infecting organisms presumbly gain entry to the peritoneal cavity via the catheter lumen or the subcutaneous tunnel through which the catheter courses before entering the cavity. The vast majority of cases are of bacterial origin with *Staphylococcus aureus* and *Staphylococcus epidermidis* responsible for about three-quarters of episodes. Gram-negative species are the etiology in about 20 percent of cases. A small number of infections are caused by mycobacteria or fungi.[70]

Peritonitis associated with CAPD initially may manifest only as clouding of the drained dialysate without pain or fever. The presence of greater than 100 white blood cells/mm^3 in the drained dialysate is considered evidence of peritonitis. Such uncomplicated cases can be treated with the addition of antibiotics to the dialysate and continuation of the CAPD schedule. A cephalosporin and an aminoglycoside typically are employed, and the appropriate antibiotic continued when the offending organism is identified. Patient technqiue is reviewed carefully, as errors or omissions may have precipitated the infection. Failure to eradicate the infection or repeated episodes of peritonitis may necessitate removal of the dialysis catheter and transfer to hemodialysis.[70]

In-line bacterial filters now are available and preliminary studies of these devices are encouraging.[71] A device which uses ultraviolet radiation to sterilize the spike connection recently was released for patient use. These and other modifications in the CAPD technique may lessen the incidence of peritonitis in the future.

Peritoneal dialysis may be administered in other fashions. A cycling machine is available that automatically performs several exchanges overnight while th patient sleeps. A two-liter dialysate volume dwells i the abdomen during the day, and the patient agai connects to the cycler when retiring. This techniqu known as continuous cyclic peritoneal dialysis (CCPD eliminates the need for a patient to interrupt dai activities to perform dialysate exchanges. It remains t be seen whether this modality is intrinsically superi to CAPD.

Peritoneal dialysis may be administered thrice weel ly, with hourly exchanges performed for 10 to 12 hour This technique, known as intermittent peritone dialysis (IPD), usually is performed in a dialysis uni It is typically reserved for the debilitated, often elder individual who cannot receive other forms of per toneal dialysis and who cannot tolerate chroni hemodialysis. However, 30 to 40 hours of intermitter peritoneal dialysis weekly may not provide sufficier dialysis if residual renal function is very low.[72] should not be considered for the otherwise health end-stage renal disease patient.

It is difficult to compare peritoneal dialysis wit hemodialysis. The majority of patients with end-stag renal disease in this country receive chroni hemodialysis, and patients previously relegated to per toneal dialysis may constitute a different subgrou with respect to cardiovascular disease, diabete mellitus, and other risk factors. Nevertheless, whe compared with chronic hemodialysis, CAPD ca achieve comparable degrees of biochemical and flui control.[73] Whether CAPDs augmented clearance c middle molecules results in improved morbidity is a yet an unproved expectation. A disturbing aspect c CAPD are retrospective studies showing a high drop out rate. A study of European CAPD programs showe a 51 percent drop-out rate at two years.[62] It is hope that better infection control will lead to an improve ment of this phenomenon.

SURVIVAL WITH DIALYSIS

The risk of death among patients receiving dialysi is about 20 percent per year. This figure must b viewed in light of the fact that two-thirds of dialysi patients in the United States are over 50 years old.[7] Many of these individuals have significant extrarena especially cardiovascular, diseases when beginnin dialysis therapy. It is not surprising then, that th majority of deaths in the end-stage renal disease popu lation are of cardiovascular etiologies. Survival o younger patients (less than 50 years old) receivin dialysis is superior (90 percent at 1 year).[74] There i no doubt that chronic dialysis affords increased lon gevity to the majority of patients with end-stage rena disease. Whether chronic dialysis sustains an ac ceptable quality of life is a more difficult issue to ad dress. A recent study analyzed the level of physica activity and employment status of nearly 2,500 dialysi patients. Sixty percent of nondiabetic patients wer capable of physical activity beyond that of self-care This figure was only 23 percent for the diabetic group Fifty-two percent of nondiabetic men were un employed.[75]

Although these results may not be an accurate reflec tion of the entire end-stage renal disease program, they do point out that dialysis, while capable of sustaining

fe, cannot be expected to improve other significant athology that may have led to renal disease in the first lace. Nevertheless, chronic dialysis permits housands of individuals who would otherwise be dead lead useful and satisfying lives. That many patients ow are receiving their second decade of chronic ialysis is a significant testament to this remarkable echnology.[76]

EFERENCES

1. Luke R: Renal replacement therapy. *N Engl J Med* 08:1593-1595, 1983.
2. Drukker W: Haemodialysis: A historical review, in: Drukker W, Parsons F, Maher J (eds): *Replacement of Renal Function by Dialysis.* The Hague, Martinus Nijhoff, 1978, pp. 3-37.
3. Abel JJ, Rowntree LG, Turner BB: On the removal of iffusable substances from the circulating blood of living nimals by dialysis. *J Pharmacol Exp Ther* 5:275-316, 1918.
4. Quinton W, Dillard D, Scribner B: Cannulation of blood essels for prolonged hemodialysis. *Trans Am Soc Artif Intern rgans* 6:104-113, 1960.
5. Blagg C: Cost of dialysis and transplantation, in: Friedan E (ed): *Strategy in Renal Failure.* New York, NY, John iley & Sons, 1978, pp. 483-503.
6. Hostetter T, Brenner B: Glomerular adaptations to renal njury, in: Brenner B, Stein J (eds): *Chronic Renal Failure.* ew York, NY, Churchill Livingstone, 1981, pp. 1-27.
7. Brenner B, Meyer T, Hostetter T: Dietary protein intake nd the progressive nature of kidney disease: The role of emodynamically mediated glomerular injury in the athogenesis of progressive glomerular sclerosis in aging, nal ablation, and intrinsic renal disease. *N Engl J Med* 07:652-659, 1982.
8. Brescia M, Cimino J, Appel K, Hurwich B: Chronic emodialysis using venipuncture and a surgically created rteriovenous fistula. *N Engl J Med* 275:1089-1092, 1966.
9. Friedman E: Pre-end-stage assessment of the azotemic atient, in: Friedman E (ed): *Strategy in Renal Failure.* New ork, NY, John Wiley & Sons, 1978, p. 7-44.
10. Mitch W: Conservative management of chronic renal ilure, in: Brenner B, Stein J (eds): *Chronic Renal Failure.* ew York, NY, Churchill Livingstone, 1981, pp. 116-152.
11. Kurtzman N: Chronic renal failure: Metabolic and inical consequences. *Hosp Pract* 17(8):107-122, 1982.
12. Samar R: Bicarbonate and acetate in hemodialysis. *ontemporary Dialysis* August 1981, pp. 10-23.
13. Funck-Brentano J-L, Man N: The polyacrylonitrile embrane and the rhodial system: Their practical appliation, in: Drukker W, Parsons F, Maher J (eds): *Replacement Renal Function by Dialysis.* The Hague, Martinus Nijhoff, 978, pp. 125-134.
14. Drukker W, Parsons F, Gordon A: Practical application dialysate regeneration: The Redy system, in: Drukker W, arsons F, Maher J (eds): *Replacement of Renal Function by ialysis.* The Hague, Martinus Nijhoff, 1978, pp. 244-258.
15. Coburn J, Slatopolsky E: Vitamin D, parathyroid ormone, and renal osteodystrophy, in: Brenner B, Rector F ds): *The Kidney. 2nd Edition.* Philadelphia, PA, W.B. aunders Co., 1981, pp. 2213-2305.
16. Bolton C, Baltzan M, Baltzan R: Effects of renal transantation on uremic neuropathy. *N Engl J Med* 34:1170-1175, 1971.
17. Babb A, Popovich R, Christopher T, Scribner B: The nesis of the square meter-hour hypothesis. *Trans Am Soc rtif Intern Organs* 17:81-91, 1971.
18. Navarro J, Contreras P, Touraine J, et al.: Are 'middle olecules' responsible for toxic phenomena in chronic renal ilure? *Nephron* 32:301-307, 1982.
19. Contreras P, Later R, Navarro J, et al.: Molecules in the iddle molecular weight range. *Nephron* 32:193-201, 1982.
20. Lowrie E, Laird N, Parker T, Sargent J: Effect of the emodialysis prescription on patient morbidity. *N Engl J Med* 05:1176-1181, 1981.
21. Bricker N: On the pathogenesis of the uremic state. *N ngl J Med* 286:1093-1099, 1972.
22. Kopple J, Swendseid M: Vitamin nutrition in patients undergoing maintenance hemodialysis. *Kidney Int* 7:S79-S84, 1975.
23. Muther R, Bennett W: Drug metabolism in renal failure, in: Brenner B, Stein J (eds): *Chronic Renal Failure.* New York, NY, Churchill Livingstone, 1981, pp. 287-323.
24. Bennett W, Aronoff G, Morrison G, et al.: Drug prescribing in renal failure: Dosing guidelines for adults. *Am J Kid Dis* 3:155-193, 1983.
25. Kjellstrand C: The Achilles' heel of the hemodialysis patient. *Arch Intern Med* 138:1063-1064, 1978.
26. Butt K: Vascular concerns in preparing for end-stage care, in: Friedman E (ed): *Strategy in Renal Failure.* New York, NY, John Wiley & Sons, 1978, pp. 187-208.
27. Durack D: Prophylaxis of infective endocarditis, in: Mandell G, Douglas G, Bennett J (eds): *Principles and Practice of Infectious Diseases.* New York, NY, John Wiley & Sons, 1979, pp. 701-710.
28. Dobkin J, Miller M, Steigbigel N: Septicemia in patients on chronic hemodialysis. *Ann Intern Med* 88:28-33, 1978.
29. Cross A, Steigbigel R: Infective endocarditis and access site infections in patients on hemodialysis. *Med* 55:453-466, 1976.
30. Vertes V, Cangiano J, Berman L, Gould A: Hypertension in end-stage renal disease. *N Engl J Med* 280:978-981, 1969.
31. Pettinger W, Mitchell H: Minoxidil—an alternative to nephrectomy for refractory hypertension. *N Engl J Med* 289:167-171, 1973.
32. Shinaberger J, Brautbar N, Miller J, Gardner P: Successful application of sequential hemofiltration followed by diffusion dialysis with standard dialysis equipment. *Trans Am Soc Artif Intern Organs* 24:677-681, 1978.
33. Leehey D, Daugirdas J, Ing T: Early drainage of pericardial effusion in patients with dialysis pericarditis. *Arch Intern Med* 143:1673-1675, 1983.
34. Osanloo E, Shalhoub R, Cioffi R, Parker R: Viral pericarditis in patients receiving hemodialysis. *Arch Intern Med* 139:301-303, 1979.
35. Caro J, Brown S, Miller O, et al.: Erythropoietin levels in uremic nephric and anephric patients. *J Lab Clin Med* 93:449-458, 1979.
36. Ohno Y, Rege A, Fisher J, Barona J: Inhibitors of erythroid colony-forming cells (CFU-E and BFU-E) in sera of azotemic patients with anemia of renal disease. *J Lab Clin Med* 92:916-923, 1978.
37. Radtke H, Frei U, Erbes P, et al.: Improving anemia by hemodialysis: Effect on serum erythropoietin. *Kidney Int* 17:382-387, 1980.
38. Gokal R, Millard P, Weatherall D, et al.: Iron metabolism in haemodialysis patients. *Quart J Med* 48:369-391, 1979.
39. Ali M, Fayemi O, Rigolosi R, et al.: Hemosiderosis in hemodialysis patients. *JAMA* 244:343-345, 1980.
40. Longnecker R, Goffinet J, Hendler E: Blood loss during maintenance hemodialysis. *Trans Amer Soc Artif Int Organs* 20:135-141, 1974.
41. Hendler E, Goffinet J, Ross S, et al.: Controlled study of androgen therapy in anemia of patients on maintenance hemodialysis. *N Engl J Med* 291:1046-1051, 1974.
42. Opelz G, Terasaki P: Improvement of kidney-graft survival with increased numbers of blood transfusions. *N Engl J Med* 299:799-803, 1978.
43. Moore S: The enigma of blood transfusions and kidney transplantation. *Mayo Clin Proc* 57:431-438, 1982.
44. Stewart J, Castaldi P: Uremic bleeding: A reversible platelet defect corrected by dialysis. *Quart J Med* 36:409-423, 1967.
45. Janson P, Jubelirer S, Weinstein M, Deykin D: Treatment of the bleeding tendency in uremia with cryoprecipitate. *N Engl J Med* 303:1318-1322, 1980.
46. Mannucci P, Remuzzi G, Pusineri F, et al.: Deamino-8-D-arginine vasopressin shortens the bleeding time in uremia. *N Engl J Med* 308:8-12, 1983.
47. Avioli L, Teitelbaum S: Renal ostcodystrophy, in: Earley L, Gottschalk C (eds): *Strauss and Welt's Diseases of the Kidney. 3rd Edition.* Boston, MA, Little, Brown & Co., 1979, pp. 307-370.
48. Potasman I, Better O: The role of secondary hyperparathyroidism in the anemia of chronic renal failure. *Nephron* 33:229-231, 1983.
49. Avram M, Feinfeld D, Huatuco A: Search for the uremic

toxin. *N Engl J Med* 298:1000-1003, 1978.

50. Hodsman A, Sherrard D, Wong E, et al.: Vitamin-D-resistant osteomalacia in hemodialysis patients lacking secondary hyperparathyroidism. *Ann Intern Med* 94:629-637, 1981.

51. Brown D, Dawsorn J, Ham K, Xipell J: Treatment of dialysis osteomalacia with desferrioxamine. *Lancet* II:343-345, 1982.

52. Goldblum S, Reed W: Host defenses and immunologic alterations associated with chronic hemodialysis. *Ann Intern Med* 93:597-613, 1980.

53. Szmuness W, Prince A, Grady G, et al.: Hepatitis B infection. *JAMA* 227:901-906, 1974.

54. Lundin A, Adler A, Berlyne G, Friedman E: Tuberculosis in patients undergoing maintenance dialysis. *Am J Med* 67:597-602, 1979.

55. Simberkoff M, Schiffman G, Katz L, et al.: Pneumococcal capsular polysaccharide vaccination in adult chronic hemodialysis patients. *J Lab Clin Med* 96:363-370, 1980.

56. Raskin N, Fishman R: Neurologic disorders in renal failure. *N Engl J Med* 294 (Part I):143-148, 294 (Part II):204-210, 1976.

57. Sideman S, Manor D: The dialysis dementia syndrome and aluminum intoxication. *Nephron* 31:1-10, 1982.

58. Manzler A, Schreiner A: Copper-induced acute hemolytic anemia. *Ann Intern Med* 73:409-412, 1970.

59. Yawata Y, Howe R, Jacob H: Abnormal red cell metabolism causing hemolysis in uremia. *Ann Intern Med* 79:362-367, 1973.

60. Hindman S, Favero M, Carson L, et al.: Pyrogenic reactions during haemodialysis caused by extramural endotoxin. *Lancet* II:732-734, 1975.

61. Leong A, Disney A, Gove D: Spallation and migration of silicone from blood-pump tubing in patients on hemodialysis. *N Engl J Med* 306:135-140, 1982.

62. Nolph K, Boen F, Farrell P, Pyle K: Continuous ambulatory peritoneal dialysis in Australia, Europe, and the United States: 1981. *Kidney Int* 23:3-8, 1983.

63. Ganter G: Ueber die Beseitigung giftiger Stoffe aus dem Blute durch Dialyse. *Munch Med Wochenschr* 70:1478-148 1923.

64. Popovich R, Moncrief J, Nolph K, et al.: Continuou ambulatory peritoneal dialysis. *Ann Intern Med* 88:449-45 1978.

65. Nolph K, Popovich R, Ghods A, Twardowski Z: Determ nants of low clearances of small solutes during peritone dialysis. *Kidney Int* 13:117-123, 1978.

66. Nolph K, Sorkin M: Continuous ambulatory peritone dialysis, in: Brenner B, Stein J (eds): *Chronic Renal Failur* New York, NY, Churchill Livingstone, 1981, pp. 193-218.

67. Levey A, Harrington J: Continuous peritoneal dialysi for chronic renal failure. *Med* 61:330-338, 1982.

68. Rottembourg J, Shahat Y, Agrafiotis A, et al.: Contin ous ambulatory peritoneal dialysis in insulin-dependent di betic patients: A 40-month experience. *Kidney Int* 23:40-4 1983.

69. Twardowski Z, Prowant B, Nolph K, et al.: High volum low frequency continuous ambulatory peritoneal dialysi *Kidney Int* 23:64-70, 1983.

70. Vas S: Microbiologic aspects of chronic ambulator peritoneal dialysis. *Kidney Int* 23:83-92, 1983.

71. Ash S, Horswell R, Heeter E, Bloch R: Effect of th peridex® filter on peritonitis rates in a CAPD populatio *Peritoneal Dialysis Bulletin* 3:89-93, 1983.

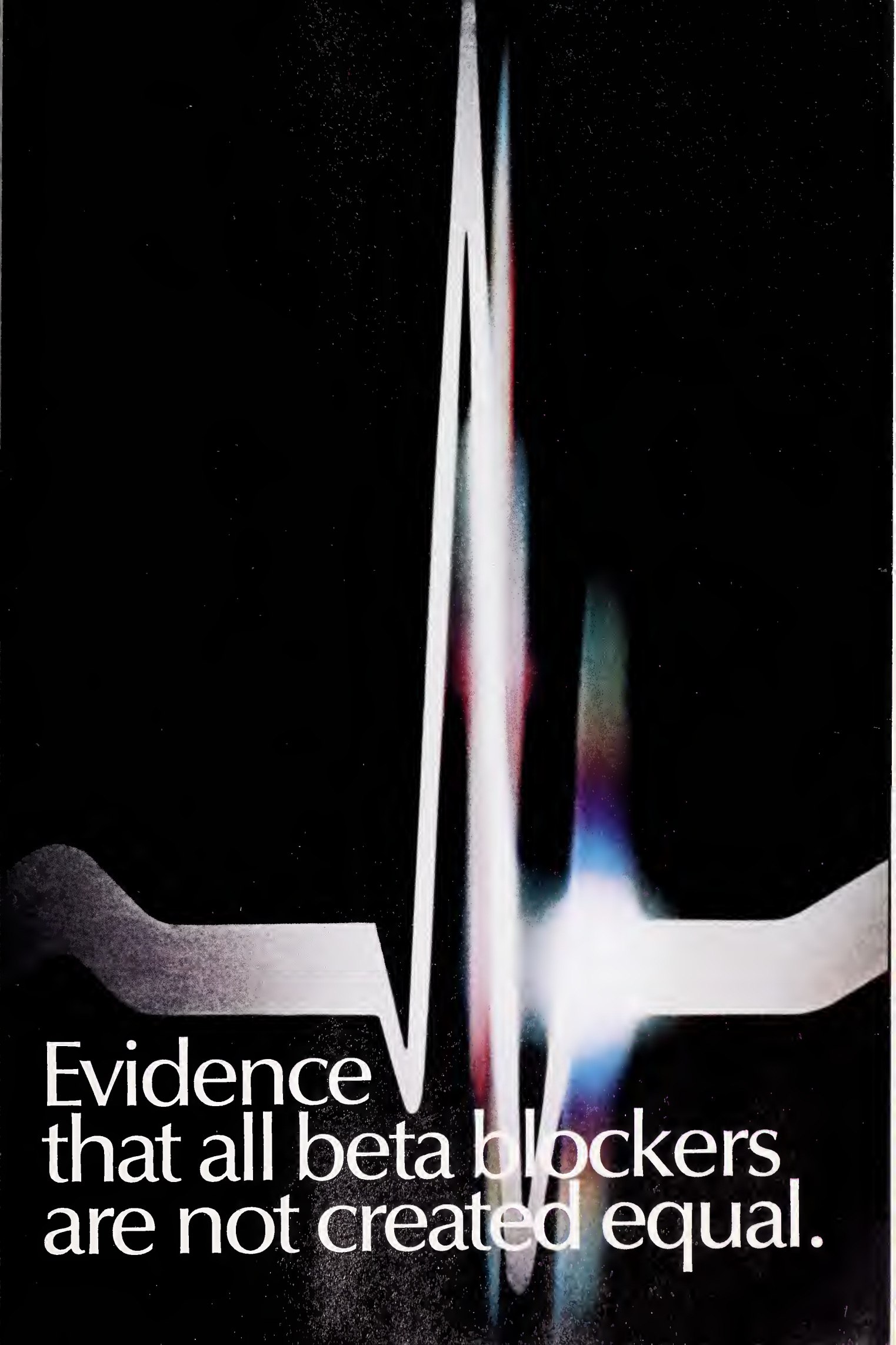
72. Ahmad S, Gallagher N, Shen F: Intermittent peritone dialysis: Status reassessed. *Trans Am Soc Artif Intern Organ* 25:86-89, 1979.

73. Nolph K, Sorkin M, Rubin J, et al.: Continuous am bulatory peritoneal dialysis: Three-year experience at on center. *Ann Intern Med* 92:609-613, 1980.

74. Krakauer H, Grauman J, McMullan M, Creede C: Th recent U.S. experience in the treatment of end-stage ren disease by dialysis and transplantation. *N Engl J Me* 308:1558-1563, 1983.

75. Gutman R, Stead W, Robinson R: Physical activity an employment status of patients on maintenance dialysis. *N Engl J Med* 304:309-313, 1981.

76. Neff M, Eiser A, Slifkin R, et al.: Patients surviving 1 years of hemodialysis. *Am J Med* 74:996-1004, 1983.


Evidence
that all beta blockers
are not created equal.

New studies uncover the potassium effects of beta-2 blockade



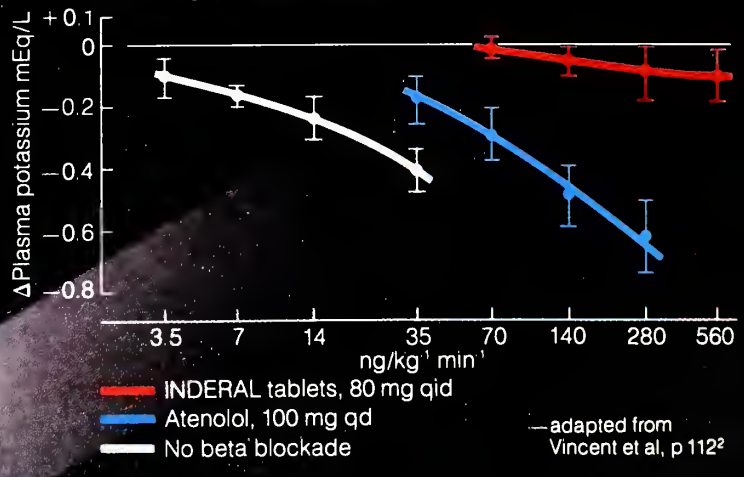
Clinical pharmacology data from the *New England Journal of Medicine:*

"...when normal young men are given infusions of epinephrine at levels such as those that circulate in patients with myocardial infarction, their serum potassium concentrations fall by about 0.8 mmol per liter. Hypokalemia is prevented by...beta-2 blockade."[1]

INDERAL (propranolol HCl) prevented beta-2 mediated hypokalemia

In a pharmacological study comparing INDERAL with atenolol, 10 hypertensive patients were infused with the nonselective beta agonist, isoproterenol, which also stimulates beta-2 mediated hypokalemia. At doses high enough to overcome beta-1 mediated heart rate reductions, the hypokalemia caused by isoproterenol was blunted by INDERAL, but not by atenolol.[2]

INDERAL compared with atenolol: change in plasma potassium after beta-agonist infusion[2]

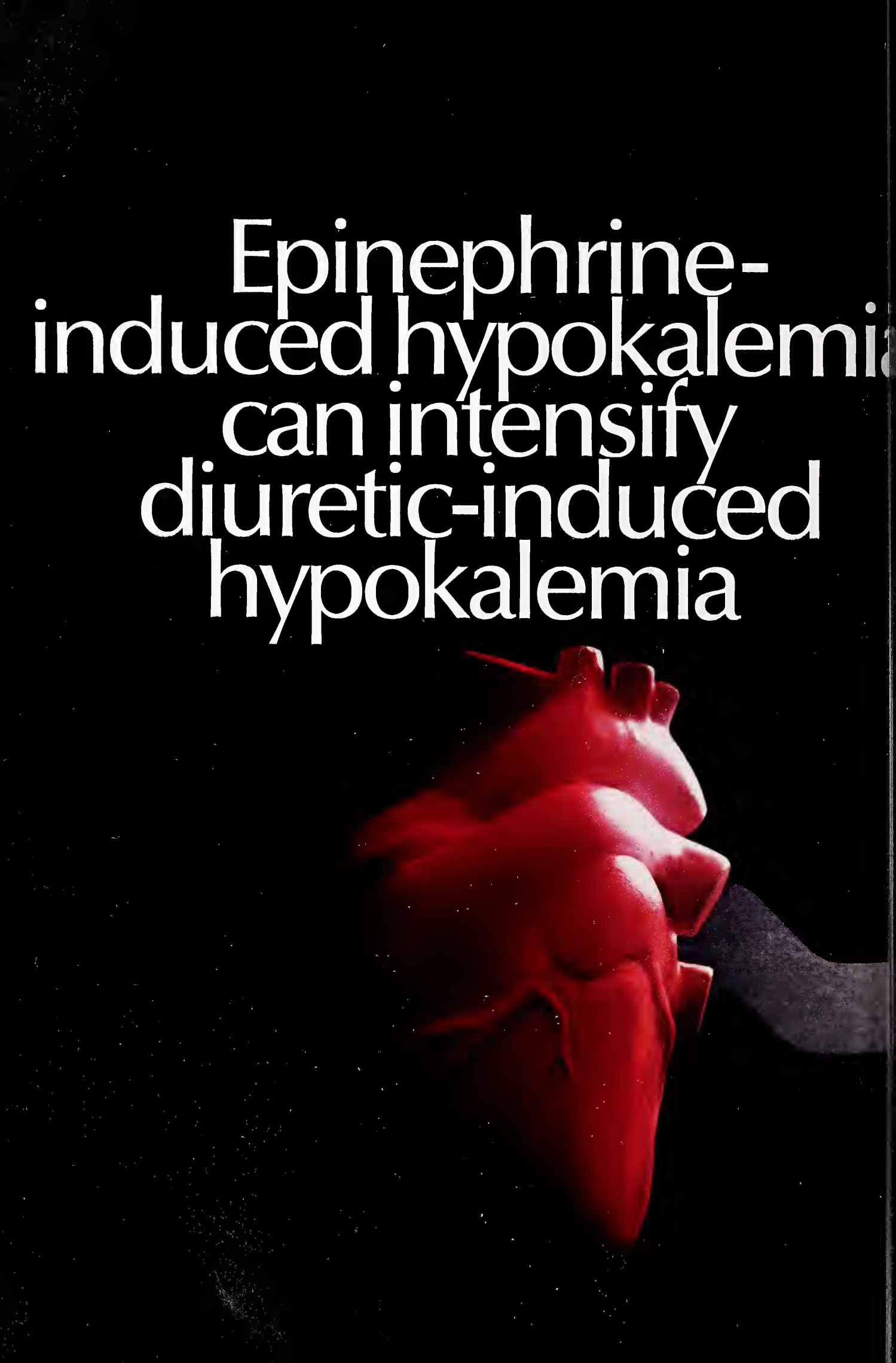


—adapted from Vincent et al, p 112[2]

For beta-1/beta-2 blockade INDERAL® (PROPRANOLOL HCl) TABLETS

Please see last page for brief summary of prescribing information.

Epinephrine-induced hypokalemia can intensify diuretic-induced hypokalemia



From the *Lancet:*

"Although both diuretics and adrenaline are known to cause hypokalaemia, we believe that this is the first demonstration that these two factors can act in an additive manner. Routine monitoring of serum potassium in patients on thiazide diuretics may underestimate the risks of hypokalaemia." [3]

Epinephrine drives potassium into cells—an effect that has been shown to be under beta-2 receptor control[4]; thiazides promote excretion of potassium. When these actions occur together, hypokalemia can intensify significantly.[3]

Epinephrine-induced hypokalemia can cause ECG abnormalities typical of other forms of hypokalemia

In a study of the effects of epinephrine-induced hypokalemia on the electrocardiogram, it was shown that levels of plasma epinephrine similar to those observed during myocardial infarction can produce changes in ventricular repolarization, which are reflected in T-wave flattening and QT prolongation in normal subjects.[5]

In clinical pharmacology studies of hypertensive and normal patients, epinephrine-induced hypokalemia was prevented by beta-2 blockade.[2,4]

For beta-1/beta-2 blockade

INDERAL®
(PROPRANOLOL HCl) TABLETS

Please see last page for brief summary of prescribing information.

Right from the start in hypertension...



Once-daily INDERAL LA (propranolol HCl) for smooth blood pressure control without the potassium problems of diuretics

Patients with "uncomplicated" hypertension may develop ventricular arrhythmias in the presence of hypokalemia.[6] Once-daily INDERAL LA maintains smooth blood pressure reductions without a negative effect on serum potassium and provides patients with broad cardiovascular benefits—all in a convenient daily dose.

Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

And for lifetime benefits in foundation treatment of angina

Once-daily INDERAL LA provides 24-hour control of angina symptoms—plus the cardiovascular benefits of the world's leading beta blocker. And unlike calcium channel blockers, INDERAL LA, alone or with a nitrate, is recommended for first-line treatment of stable angina.

Simply start new patients on 80 mg INDERAL LA once daily. Dosage may be increased to 160 mg once daily to achieve maximal control.

Once-daily
INDERAL® LA
(PROPRANOLOL HCl) LONG ACTING CAPSULES
In HYPERTENSION and ANGINA



The appearance of these capsules is a registered trademark of Ayerst Laboratories.
Please see last page for brief summary of prescribing information.

INDERAL®
(PROPRANOLOL HCl) TABLETS



10 mg 20 mg 40 mg 60 mg 80 mg 90 mg

The appearance of these tablets is a registered trademark of Ayerst Laboratories.

Once-daily INDERAL® LA
(PROPRANOLOL HCl) LONG ACTING CAPSULES



The appearance of these capsules is a registered trademark of Ayerst Laboratories.

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULARS.)*

INDERAL® (propranolol hydrochloride) **Tablets and Injectable**
INDERAL® LA (propranolol hydrochloride) **Long Acting Capsules**

INDICATIONS AND USAGE—INDERAL Tablets

Hypertension: INDERAL (propranolol hydrochloride) is indicated in the management of hypertension. It may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL is indicated for the long-term management of patients with angina pectoris.

Cardiac Arrhythmias:

1.) Supraventricular arrhythmias

a) Paroxysmal atrial tachycardias, particularly those arrhythmias induced by catecholamines or digitalis or associated with the Wolff-Parkinson-White syndrome. (See W-P-W under WARNINGS.) b) Persistent sinus tachycardia which is noncompensatory and impairs the well-being of the patient. c) Tachycardias and arrhythmias due to thyrotoxicosis when causing distress or increased hazard and when immediate effect is necessary as adjunctive, short term (2-4 weeks) therapy. May be used with, but not in place of, specific therapy. (See Thyrotoxicosis under WARNINGS.) d) Persistent atrial extrasystoles which impair the well-being of the patient and do not respond to conventional measures. e) Atrial flutter and fibrillation when ventricular rate cannot be controlled by digitalis alone, or when digitalis is contraindicated.

2.) Ventricular tachycardias

Ventricular arrhythmias do not respond to propranolol as predictably as do the supraventricular arrhythmias. a)Ventricular tachycardias. With the exception of those induced by catecholamines or digitalis, INDERAL is not the drug of first choice. In critical situations when cardioversion technics or other drugs are not indicated or are not effective, INDERAL may be considered. If, after consideration of the risks involved, INDERAL is used, it should be given intravenously in low dosage and very slowly. (See DOSAGE AND ADMINISTRATION.) *Care in the administration of* INDERAL *with constant electrocardiographic monitoring is essential as the failing heart requires some sympathetic drive for maintenance of myocardial tone.* b) Persistent premature ventricular extrasystoles which do not respond to conventional measures and impair the well-being of the patient.

3.) Tachyarrhythmias of digitalis intoxication

If digitalis-induced tachyarrhythmias persist following discontinuance of digitalis and correction of electrolyte abnormalities, they are usually reversible with *oral* INDERAL. Severe bradycardia may occur. (See OVERDOSAGE.) Intravenous propranolol hydrochloride is reserved for life-threatening arrhythmias. Temporary maintenance with oral therapy may be indicated. (See DOSAGE AND ADMINISTRATION in the package circulars.)

4.) Resistant tachyarrhythmias due to excessive catecholamine action during anesthesia. Tachyarrhythmias due to excessive catecholamine action during anesthesia may sometimes arise because of release of endogenous catecholamines or administration of catecholamines. When usual measures fail in such arrhythmias, INDERAL may be given intravenously to abolish them. All general inhalation anesthetics produce some degree of myocardial depression. Therefore, when INDERAL (propranolol hydrochloride) is used to treat arrhythmias during anesthesia, it should be used with extreme caution and constant ECG and central venous pressure monitoring. (See WARNINGS.)

Myocardial Infarction: INDERAL is indicated to reduce cardiovascular mortality in patients who have survived the acute phase of myocardial infarction and are clinically stable.

Migraine: INDERAL is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta receptor stimulation. Clinical improvement may be temporary.

Pheochromocytoma: After primary treatment with an alpha-adrenergic blocking agent has been instituted, INDERAL may be useful as *adjunctive* therapy if the control of tachycardia becomes necessary before or during surgery.

It is hazardous to use INDERAL unless alpha-adrenergic blocking drugs are already in use, since this would predispose to serious blood pressure elevation. Blocking only the peripheral dilator (beta) action of epinephrine leaves its constrictor (alpha) action unopposed.

In the event of hemorrhage or shock, there is a disadvantage in having both beta and alpha blockade since the combination prevents the increase in heart rate and peripheral vasoconstriction needed to maintain blood pressure.

With inoperable or metastatic pheochromocytoma, INDERAL may be useful as an adjunct to the management of symptoms due to excessive beta receptor stimulation.

INDICATIONS AND USAGE—INDERAL LA Long Acting Capsules

Hypertension: INDERAL LA (propranolol hydrochloride) is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL and INDERAL LA are contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital compor supporting circulatory function in patients with congestive heart failure, and its inhibitior beta blockade may precipitate more severe failure. Although beta blockers should avoided in overt congestive heart failure, if necessary, they can be used with close follov in patients with a history of failure who are well compensated and are receiving digitalis diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitali heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta bloc can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of h failure, the patient should be digitalized and/or treated with diuretics, and the respo observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation angina and, in some cases, myocardial infarction, following abrupt discontinuance INDERAL (propranolol hydrochloride) therapy. Therefore, when discontinuance INDERAL is planned the dosage should be gradually reduced over at least a few week and the patient should be cautioned against interruption or cessation of therapy witho the physician's advice. If INDERAL therapy is interrupted and exacerbation of angi occurs, it usually is advisable to reinstitute INDERAL therapy and take other measur appropriate for the management of unstable angina pectoris. Since coronary arte disease may be unrecognized, it may be prudent to follow the above advice in patier considered at risk of having occult atherosclerotic heart disease who are given pr pranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysem

PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECI BETA BLOCKERS. INDERAL should be administered with caution since it may block t chodilation produced by endogenous and exogenous catecholamine stimulation of receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking the prior to major surgery is controversial. It should be noted, however, that the impaired abil the heart to respond to reflex adrenergic stimuli may augment the risks of general anesth and surgical procedures.

INDERAL, like other beta blockers, is a competitive inhibitor of beta-receptor agonists its effects can be reversed by administration of such agents, e.g., dobutamine or proterenol. However, such patients may be subject to protracted severe hypoten Difficulty in starting and maintaining the heartbeat has also been reported with blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the pearance of certain premonitory signs and symptoms (pulse rate and pressure change acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroic Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of s toms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid tion tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have reported in which, after propranolol, the tachycardia was replaced by a severe bradyca requiring a demand pacemaker. In one case this resulted after an initial dose of 5 propranolol.

PRECAUTIONS. *General:* Propranolol should be used with caution in patients impaired hepatic or renal function. INDERAL is not indicated for the treatment of hyperter emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Pat should be told that INDERAL may interfere with the glaucoma screening test. Withdr may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart dise elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as r pine should be closely observed if INDERAL is administered. The added catecholar blocking action may produce an excessive reduction of resting sympathetic nervous ac which may result in hypotension, marked bradycardia, vertigo, syncopal attack orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studi both rats and mice, employing doses up to 150 mg/kg/day, there was no evidenc significant drug-induced toxicity. There were no drug-related tumorigenic effects at a the dosage levels. Reproductive studies in animals did not show any impairment of fe that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotox animal studies at doses about 10 times greater than the maximum recommended hu dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL sh be used during pregnancy only if the potential benefit justifies the potential risk to the f

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block; h tension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usua the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insor lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; v disturbances; hallucinations; an acute reversible syndrome characterized by disorient for time and place, short-term memory loss, emotional lability, slightly clouded senso and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diar constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with ac and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytop purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male i tence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reac involving the skin, serous membranes and conjunctivae reported for a beta blocker (p tolol) have not been associated with propranolol.

REFERENCES.

1. Epstein FH, Rosa RM: Adrenergic control of serum potassium. *N Engl J* 1983;309:1450-1451. **2.** Vincent HH, Boomsma F, Man in't Veld AJ, et al: Effects of sele and nonselective β-agonists on plasma potassium and norepinephrine. *J Cardiovasc macol* 1984;6:107-114. **3.** Struthers AD, Whitesmith R, Reid JL: Prior thiazide diuretic ment increases adrenaline-induced hypokalaemia. *Lancet* 1983;1:1358-1361. **4.** Brow Brown DC, Murphy MB: Hypokalemia from beta$_2$-receptor stimulation by circulating nephrine. *N Engl J Med* 1983;309:1414-1419. **5.** Struthers AD, Reid JL, Whitesmith R, Effect of intravenous adrenaline on electrocardiogram, blood pressure, and serum tassium. *Br Heart J* 1983;49:90-93. **6.** Holland OB, Nixon JV, Kuhnert L: Diuretic-ind ventricular ectopic activity. *Am J Med* 1981;70:762-768.

9410/

Ayerst® AYERST LABORATORIES
New York, N.Y. 10017

Copyright © 1984 AYERST LABORATORIES
Division of AMERICAN HOME PRODUCTS CORPORATION

CLIP & SAVE

The Medical Society of New Jersey and the Healthcare Information Network

Television Program Guide
September-May

osed circuit television programs related to issues and concerns of physician members of MSNJ.

- **PRESIDENT'S FORUM:** hosted by Frank Y. Watson, M.D., President, MSNJ
- **THE IMPAIRED PHYSICIAN:** hosted by David I. Canavan, M.D., Director, Impaired Physicians Program, MSNJ
- **STATE OF THE ART:** hosted by Howard D. Slobodien, M.D., Past President, MSNJ

ograms will be featured the first, second, and third Tuesday of each month at 1:00 P.M. There will be 800 number for viewer participation.

esented solely through those New Jersey hospitals which are subscribers to the **HIN** closed circuit levision network. A listing of participating hospitals is on the bottom of this page.

r additional information or comments, contact the Medical Society of New Jersey, Department of Special ojects, A. Ronald Rouse, Director.

President's Forum

nk Y. Watson, M.D., President of Medical Society of New Jersey, host this program with selected mbers from the Board of Trustees appropriate Council and Committee Chairpersons who will present information discussed at the previous ard meetings.

time for this program is financed the Medical Society of New Jersey.

Tuesday, October 2, 1984
Tuesday, November 6, 1984
Tuesday, December 4, 1984
Tuesday, January 1, 1985
Tuesday, February 5, 1985
Tuesday, March 5, 1985
Tuesday, April 2, 1985
Tuesday, May 7, 1985

The Impaired Physician

Air time for this program is financed by the Health Care Insurance Exchange (HCIE) and the Princeton Insurance Company (PIC).

Tuesday, September 11, 1984
"Acute Case of the Impaired Physician"

Tuesday, October 9, 1984
"Rehabilitation Programs"

Tuesday, November 13, 1984
"Aftercare"

Tuesday, December 11, 1984
"The Family and The Disease"

Tuesday, January 8, 1985
"Support Groups"

Tuesday, February 12, 1985
"Problems of Re-Entry"

Tuesday, March 12, 1985
"Followup/Monitoring"

Tuesday, April 9, 1985
"Recidivism/Special Problems"

State of the Art

Air time for this program is financed by the Medical Society of New Jersey.

Tuesday, October 16, 1984
Professional Liability
James E. George, M.D., J.D.
and
Mr. Adam Wilczek

Tuesday, November 20, 1984
Continuing Medical Education
Paul Hirsch, M.D.,
Edwin Messey, M.D.
and
Robert Rigolosi, M.D.

Tuesday, December 18, 1984
MSNJ Legislative Activities
Mr. Joseph Katz
and
Mr. Clark Martin

The following programs will be announced at a later date:

Tuesday, January 15, 1985
Tuesday, February 19, 1985
Tuesday, March 19, 1985
Tuesday, April 16, 1985
Tuesday, May 21, 1985

rticipating Hospitals*: Beth Israel Hospital; Freehold Area Hospital; Memorial General Hospital; Morown Memorial Hospital; Northern Ocean Hospital System, Inc.; Pascack Valley Hospital; Saint Elizabeth spital; Saint Mary's Hospital; Saint Peter's Medical Center; and Underwood-Memorial Hospital.

spitals Declaring a Preliminary Interest: Atlantic City Medical Center; ACMC-Mainland Division; Betty charach Rehab. Hospital; Bridgeton Hospital; Carrier Foundation; Clara Maass Medical Center; Community Memorial Hospital; Deborah Heart & Lung Center; Englewood Hospital Association; Hackensack dical Center; Holy Name Hospital; Hospital Center at Orange; John F. Kennedy Medical Ctr.; KMH/UMC-atford Division; Kessler Institute for Rehab.; Monmouth Medical Center; Muhlenberg Hospital; Newark h Israel Medical Ctr.; Newton Memorial Hospital; Riverside Hospital; Salem County Memorial Hospital; d Saint Clare's Hospital; Saint Francis Medical Center; Warren Hospital; West Hudson Hospital; and West sey Hospital-Northern Division.

sting of hospitals may have changed since this printing.

CLIP & SAVE

Pharmacological Basis of Therapeutics: Dopamine Receptors*

Richard E. Heikkila, Ph.D., Piscataway**

Drugs that interact with dopamine receptors, either to facilitate or to inhibit their actions, are important clinically. Dopamine receptor agonists commonly are used to treat Parkinson patients. In contrast, dopamine receptor antagonists commonly are used as antipsychotic agents. An understanding of how these drugs interact with their specific receptors is of clinical significance.

Dopamine (3,4-dihydroxyphenylethylamine) is formed from dietary tyrosine after the actions of the enzymes, tyrosine hydroxylase and dopa decarboxylase (Table 1). The enzyme dopamine-beta-hydroxylase, which is missing from dopamine neurons, forms norepinephrine from dopamine within norepinephrine neurons. As recently as 1957, dopamine was thought to be only an inactive precursor of norepinephrine and to have no real importance of its own.

After its release from its presynaptic storage pool into a synaptic cleft, a number of things can happen to dopamine. Firstly, and probably most importantly, dopamine can bind to its receptors on a postsynaptic membrane. This binding of dopamine to its receptor is an initial step in a cascade of events which ultimately results in a biological response, e.g. movement. Synaptically released dopamine also can be inactivated and it is thought that the major mechanism for the inactivation of dopamine is its reuptake back into the presynaptic neuron. Dopamine also is inactivated by the actions of the degradative enzymes, catechol-o-methyl-transferase and monoamine oxidase. This latter enzyme exists in at least two different forms, a monoamine oxidase A and a monoamine oxidase B.

There are several distinct dopamine pathways within the mammalian central nervous system. The nigrostriatal dopaminergic system, which is important in proper motor coordination, is degenerated i Parkinson's disease. A second dopamine system, th tuberoinfundibular, controls the release of pituitar hormones such as prolactin. A third dopamine syster the mesolimbic, is thought to be involved with th regulation of emotional behavior. For example, it is fel that schizophrenics have an overactive mesolimbi dopamine system and that the antipsychotic effects c neuroleptic drugs are due to their blockade of over active dopamine receptors in areas of the brain in nervated by the mesolimbic dopamine system.[7]

Besides the above-mentioned antipsychotic agents there are several clinically used drugs that modulat dopaminergic activity. For example, l-dopa, the direc precursor of dopamine, and other directly actin dopaminergic agonists such as bromocriptine lergotrile, and pergolide, successfully have been use in the treatment of Parkinson's disease. In addition t

*This article, sixth in a series, prepared under the leadership of Bruce McL. Breckenridge, M.D., Chairman, Department o Pharmacology, UMDNJ-Rutgers Medical School, is a brief re view of recent advances in pharmacology and relate preclinical sciences, which will help readers to understand the action of new and established therapeutic agents. The reviews do not consider indications for specific drugs, incom patibilities, or dosage forms, which can be found in the *AMA Drug Evaluations, 5th Edition*, 1983.

**From the Department of Neurology, UMDNJ-Rutgers Medical School. Correspondence may be addressed to Dr. Heikkila UMDNJ-Rutgers Medical School, Piscataway, NJ 08854.

TABLE 1



heir use as antiparkinsonian agents, several dopmine agonists have been used to control the secretion prolactin. Mazindol, a compound which blocks the uptake of synaptically released dopamine, is used as n anorexic agent while yet another dopamine uptake locker, nomifensine, is utilized in Europe as an antiepressant.

In addition to these beneficial drugs, several drugs f abuse have dopaminergic activity. For example, mphetamine and cocaine facilitate the release of opamine and block the reuptake of synaptically reased dopamine, respectively. Both of these latter acons, facilitation of dopamine release and blockade of opamine reuptake, would raise the effective opamine level in the synaptic cleft that then could nteract with the dopamine receptor. It is reasonable o suggest that other dopamine uptake inhibitors or opamine-releasing agents, like cocaine and amphetmine, may have potential for abuse.

The ultimate target of all drugs that interact with opamine systems is the dopamine receptor. Drugs hat enhance dopaminergic activity lead to a greater timulation of the dopamine receptor and, conversely, lrugs that decrease dopaminergic activity lead to a liminished stimulation of the dopamine receptor. There exists considerable evidence that there are mulple classes of dopamine receptors. For the most part, his evidence has been derived from biochemical nd/or pharmacological experimentation done in vitro.

There are several schemes that exist for the classification of dopamine receptors.[1,5,6,9,11] In these various schemes, the number of subclasses of the dopamine receptor ranges from two to five. With so many classification schemes being used, it is not surprising that a great deal of confusion exists in this field. What was true yesterday in fact may not be true today! Perhaps a great deal of this confusion exists because the experiments that form the basis of the classification schemes are simple to carry out, but at the same time are difficult to interpret. And oftentimes, the appropriateness of the classification scheme is dependent upon a number of assumptions, all of which not always are obviously valid.

Probably the first classification scheme for dopamine receptors that gained a widespread acceptance was that of Kebabian and Calne (Table 2).[5] Published in 1979, this scheme is based upon the effects of a drug on adenylate cyclase activity and on prolactin secretion. According to this classification, stimulation of the D-1 dopamine receptor leads to increased cyclic AMP formation. Stimulation of the D-2 dopamine receptor leads to no increment, and in fact a decrement, in cyclic AMP formation. In contrast to its effects on cyclic AMP formation, stimulation of the D-1 receptor has no effect on prolactin secretion while stimulation of the D-2 receptor leads to an inhibition of prolactin secretion.[5] According to Kebabian and Calne, the D-1 dopamine receptors are found in several mammalian tissues including the superior cervical ganglion, the retina, the neostriatum, and the parathyroid gland. The D-2 dopamine receptors are located in various tissues, including the neostriatum and the anterior and intermediate lobes of the pituitary.

TABLE 2

Classification of Dopamine Receptor Subtypes According to Kebabian and Calne

	D-1 Receptor	D-2 Receptor
Linked to adenylate cyclase	Positively	Negatively
Specific agonist	SKF 38393	LY 141865
Specific antagonist	SCH 23390	Sulpiride

Dopamine and several other drugs including apomorphine and pergolide, stimulate both the D-1 and D-2 dopamine receptor.[2] Dopamine, for example, is known to bring about increases in levels of cyclic AMP and to inhibit prolactin secretion. In contrast, the commonly used antipsychotic agents, haloperidol and chlorpromazine, by themselves cause an increase in prolactin secretion, and additionally can prevent the dopamine mediated rise in cyclic AMP formation.[5] These two drugs, therefore, are antagonists of both the D-1 and D-2 dopamine receptors. While these drugs stimulate (or inhibit) both D-1 and D-2 receptors, there are other agents that are relatively specific and interact with one or the other of these receptor subtypes. For example, SKF 38393 is a D-1 receptor agonist and has little or no effect on D-2 receptors.[10] In contrast, LY-141865 is a D-2 receptor agonist that has little or no effect on D-1 dopamine receptors.[12] Specific antagonists also exist. SCH 23390 is a D-1 receptor antagonist[4] while sulpiride is a D-2 antagonist.[9] And if all of this is not confusing enough, there are drugs including bromocriptine and several other structurally similar ergot alkaloids that are D-1 receptor antagonists and D-2 receptor agonists.[8] It is clear from this information that the rather simple classification scheme of Kebabian and Calne for dopamine receptors can become quite complex.[5]

Another classification scheme for dopamine receptors is put forth by Seeman.[9] This classification scheme, which is based strictly on radioligand binding experiments, has four subclasses of dopamine receptors. These four subclasses are called D-1, D-2, D-3, and D-4 and are defined on the basis of their relative affinities for dopamine agonists, i.e. dopamine, and dopamine antagonists, i.e. spiperone. As defined by Seeman, the D-1 receptor has a μM affinity for dopamine agonists and a μM affinity for dopamine antagonists; the D-2 receptor has μM affinity for dopamine agonists and nM affinity for dopamine antagonists; the D-3 receptor has nM affinity for dopamine agonists and μM affinity for antagonists;

and the D-4 receptor has nM affinity for both dopamine agonists and antagonists. Another classification scheme based on radioligand binding, perhaps less popular than that of Seeman, is that of Sokoloff et al.[11] In this scheme, the D-1 and D-3 dopamine receptors are defined exactly as by Seeman. However, the definitions for the D-2 and D-4 receptors are exactly reversed in these two schemes. Stated differently, the D-2 receptor as defined by Seeman is identical to the D-4 receptor as defined by Sokoloff et al.[9,11] Accordingly, the D-4 receptor in the Seeman classification is the D-2 receptor as defined by Sokoloff et al. It is not surprising that there is confusion, at least in the minds of some. What adds even more to the confusion is that all of these binding experiments, while easy to carry out, are quite difficult to interpret. They further often rest on rather dubious assumptions, usually in what agent is used to define specific receptor binding. Even more surprising is that this rather suspect primary data often is analyzed by means of rather sophisticated computer techniques. It is clear that the method of data analysis is far superior to the method of data collection.

While there may be reservations in the minds of some, others have proceeded and seemingly made sense out of the confusion. It recently has been pointed out, again from binding experiments analyzed by sophisticated computer techniques, that a model can be constructed in which there are only two dopamine receptors.[6] In this scheme, the D-3 receptor is a high affinity agonist state of the D-1 receptor. Moreover, the D-4 receptor is the high affinity agonist state of the D-2 receptor. In this model, the D-1 and the D-3 states are interconvertible as are the D-2 and D-4 receptors. While it is too early to determine whether this model is consistent with all of the diverse experimental observations, this scheme clearly has the potential to make some method out of what has heretofore been madness. It furthermore has the potential to bring together observations based on binding experiments with observations based on adenylate cyclase experiments.

In terms of a time framework, all of these above observations on dopamine receptors have been rather recent. It is far too early to decide the physiological relevance of these various classes of dopamine receptors.[3] For example, it is not clear if the ideal ant Parkinsonian agent should possess both D-1 and D- receptor agonist properties, or in contrast should i teract with only one subclass of the dopamine recepto Conversely, it is not clear if the ideal antipsychot agent will have relative specificity or in contrast wi be an antagonist of both (all) subclasses of th dopamine receptor. It is conceivable that situation will arise in which it is desirable to have specif agonists or antagonists. It also is clear that in additio to having practical implications many of these agen have been extremely valuable tools which have helpe to further our knowledge of dopaminergic function

REFERENCES

1. Cools AR: The puzzling 'cascade' of multiple receptors f dopamine. An appraisal of the current situation. *Trends Pharmacol Sci* 2:178, 1981.
2. Fuller RW, Clemens JA, Kornfeld EC, Snoddy HI Smalstig EB, Bach NJ: Effects of (8β)-8-[(methylthio methyl]-6-propylergoline on dopaminergic function and brai dopamine turnover in rats. *Life Sci* 24:375, 1979.
3. Gershanik O, Heikkila RE, Duvoisin RC: Behavioral co relations of dopamine receptor activation. *Neurology* 33:148 1983.
4. Iorio LC, Barnett A, Leitz FH, Houser VP, Korduba C SCH 23390, a potential benzazepine antipsychotic wit unique interactions on dopaminergic systems. *J Pharmac Exp Ther* 226:462, 1983.
5. Kebabian JW, Calne DB: Multiple receptors f dopamine. *Nature* 277:93, 1979.
6. Leff SE, Creese I: Dopamine receptors re-explaine *Trends in Pharmacol Sci* 8:463, 1983.
7. Mackay AVP, Iversen LL, Rossor M, Spokes E, Bird I Arregui A., Creese I, Snyder SH: Increased brain dopamir and dopamine receptors in schizophrenia. *Arch Gen Ps chiatry* 39:991, 1982.
8. Markstein R: Neurochemical effects of some ergot deriv tives: A basis for their antiparkinson actions. *J Neural Tran* 51:39, 1981.
9. Seeman P: Nomenclature of central and peripher dopaminergic sites and receptors. *Biochem Pharmac* 31:2563, 1982.
10. Setler PE, Sarau HM, Zirkle CL, Saunders HL: The cer tral effects of a novel dopamine agonist. *Eur J Pharmac* 50:419, 1978.
11. Sokoloff P, Martres MP, Schwartz JC: Three classes dopamine receptor (D-2, D-3, D-4) identified by binding stud ies with ^{3}H-apomorphine and ^{3}H-domperidone. *Arch Pharmac col* 315:89, 1980.
12. Tsuruta K, Frey EA, Grewe CW, Cote TE, Eskay RI Kebabian JW: Evidence that LY-141865 specifically stimu lates the D-2 dopamine receptor. *Nature* 292:463, 1981.

BROWN **THE BROWN PHARMACEUTICAL CO., INC.**

2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android®/5 mg Buccal/10 mg Oral/25 mg Oral

Methyltestosterone U.S.P. Tablets

ANDROID®/F

Fluoxymesterone U.S.P. Tablets, 10 mg



DOCTOR'S NOTEBOOK

Trustees' Minutes; UMDNJ Notes; MSNJ Auxiliary: Current Legislation; Retired Lives Reserve; New Members; Physicians Seeking Location in New Jersey

Trustees' Minutes October 21, 1984

A regular meeting of the Board of Trustees was held on Sunday, October 21, 1984, at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

President's Report . . .
DRG (Medicare/Medicaid Waiver) . . . Noted that a three-year waiver extension application has been filed with the U.S. Dept. of Health and Human Services by Mr. Scibetta, NJHA, and is on file at MSNJ headquarters.

Report of Executive Director . . .
(1) MSNJ 1984 Paid Membership . . . Noted that paid membership was 7,497, as of September 28, 1984.
(2) MSNJ Financial Statements . . . Noted that financial statements for the periods ending August 1984 and September 1984 were reviewed and approved.
(3) Reinsurance Association Deficit . . . Noted that a task force is being formed by Commissioner Goldstein to study the medical malpractice deficit of the Reinsurance Association and other related issues.
(4) Medicare Fee Freeze . . . Noted that the AMA has filed a lawsuit on the Medicare amendments in the Indiana Federal District Court.
Note: By reason of the filing of a motion for preliminary injunction, members of the Indiana State Medical Association and/or the members of AMA who have not received their fee profiles from Medicare carriers were granted a 15-day filing extension.
(5) Litigation Report . . .
(a) Subordinated Loan Certificates-Internal Revenue Service . . . Noted that a report still is pending.
(b) State Board of Medical Examiners *v* Cruz . . . Agreed to participate amicus if this case is appealed.
(6) AMA Council on Long-Range Planning and Development . . . Congratulated Dr. Palma Formica on her appointment to the AMA Council on Long-Range Planning and Development.

Committee on Impaired Physicians . . . Approved the following recommendation:

That the Board of Trustees authorize the scheduling, advertising, and necessary expenditures for the spring conference on the medical family.

Audit Review Committee . . . Approved the following recommendations:

That the audited financial statements be accepted and a copy thereof forwarded to each component medical society.

That Ernst and Whinney be continued as the external auditors.

Old Business . . .
(1) 1984 Annual Meeting Resolutions . . .
(a) Blue Shield Participating Physician Agreements (Resolution #5) . . . Voted not to take legal action concerning Blue Shield's participating physician agreements.
(b) Expanded Legislative Service (Resolution #14) . . . Approved the following new procedures for informing members about legislative issues: Council on Legislation will meet quarterly with county and specialty society representatives; regulatory proposals will be subjects of special memorandums to county and specialty societies and hospital medical staffs; a section of *Th Journal* will contain a legislative up date every other month.
(c) Collective Bargaining Agent fo Physicians' Services (Resolutio #25) . . . Voted not to implemer this resolution calling for MSNJ t act as collective bargaining agent fo its members, and directed the Cour cil on Medical Services to researc and consider the development o suggested relative value guidelino for the various specialties in Ne Jersey.
(2) Public Relations Program . . Referred to the Council on Publi Relations a request from the Unio County Medical Society asking tha MSNJ implement a public relation program addressed to senio citizens in an effort to combat th new Medicare regulations and up coming DRG proposals.

New Business . . .
Physician Reimbursement in Re habilitation Hospitals . . . Voted t support the position being taken b the NJ Society of Physical Medicin and Rehabilitation which state that the practice of medicine in re habilitation institutions in New Jer sey should not be treated differentl from that practiced generally acros the country as it applies to Medicare Also, voted to refer to the Council o Medical Services for discussion th overall topic of Medicare reimburse ment.

UMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

A UMDNJ-Rutgers Medical Schoo research group has found that two drugs—pargyline and deprenil—prevent symptoms of Parkinson's disease from developing in mice. The advance was reported in the October 4, 1984, issue of *Nature*. The UMDN research team, which hopes to tes the drugs in human patients, is led by Roger C. Duvoisin, M.D., professor and chairman of the department o neurology at the medical school; he is an internationally known re search specialist on Parkinson's dis ease.

This group was the first to suc ceed in reproducing symptoms o parkinsonism in mice. That was achieved by injecting the laboratory animals with a chemical contami nant called MPTP. Then the scien-

ists found that pargyline and leprenil prevent MPTP-injected mice from developing parkinsonism symptoms.

If those drugs succeed in halting the progression of Parkinson's disease in human patients, we will be a lot closer to solving the riddle of this disorder.

Robert L. Johnson, M.D., director of adolescent medicine at UMDNJ's Newark campus, recently delivered a stern message to the Congressional Black Caucus in Washington, D.C. The associate professor of clinical pediatrics at UMDNJ-New Jersey Medical School stated that a rising tide of violence is today the major threat to youth, particularly black youth, and current methods of dealing with it are ineffective and impotent.

The violence Dr. Johnson spoke of ranges from automobile accidents to suicide and homicide and often arises from alcohol and drug abuse. While the teens are perceived as the healthiest age group, it is the only portion of the population in which the rates of violent injury and death are increasing, he said.

Dr. Johnson, speaking at the Health Brain Trust Workshop of the 14th Annual Congressional Black Caucus Legislative Weekend, called for "a new formula that will allow us to understand and respond to the violence that threatens our youth," and asserted that traditional approaches to health care are ineffective in dealing with juvenile delinquency and related problems.

The UMDNJ physician, who is black, believes that a "holistic" approach is necessary to "reach into the lives of adolescents to determine where help is needed." Traditional approaches to care must be broadened. According to Dr. Johnson, the idea is to find a void in the youth's life and then strive to fill it, through careful followup and services.

A research team headed by John W.C. Bird, Ph.D., director of the Bureau of Biological Research at Rutgers University, and Fred Roisen, M.D., acting chairman of the department of anatomy at UMDNJ-Rutgers Medical School, has reported a natural inhibitor to the cellular enzymes that cause the destruction of muscle cells in muscle diseases.

In 1977, Dr. Bird and his colleagues discovered the enzymes responsible for the wasting of muscles in diseases such as the muscular dystrophies. Since they began working collaboratively, Drs. Bird and Roisen's groups have been able to purify the enzymes, raise antibodies to the enzymes, and, with the techniques of fluorescent and electron microscopy, demonstrate the actual location and movement of the destructive enzymes in muscle cells.

The major significance of the new finding is that we now have some ideas on how the cell regulates these destructive enzymes, or proteinases, with its own endogenous inhibitor under normal conditions. With purified inhibitor and antibodies to the inhibitor now available, several exciting research possibilities exist which involve the design of better synthetic inhibitors and gene cloning. In the future, it may be possible by genetic engineering to insure that patients have enough of this inhibitor.

The Melvyn H. Motolinsky Foundation, which supports research on blood diseases, particularly leukemia, announced the first recipient of a permanent fellowship at UMDNJ-Rutgers Medical School, which houses the Foundation's Laboratory for Hematology Research at its New Brunswick campus. The Melvyn H. Motolinsky Foundation was established in 1972 in memory of its namesake, an attorney who died of leukemia in 1969 at the age of 26. Kathleen Toomey, M.D., received the $25,000 award. She is in her third year of postgraduate training at the UMDNJ school.

MSNJ Auxiliary

Grace Gellman
President

We are at the midpoint of the Auxiliary year. County community service programs are in progress.

The fundraising projects are taking shape. Those marvelous parties will be realities in a few months. It takes a year of hard work to produce such an affair, the proceeds from which benefit community-based programs, health-related scholarships, and grants or loans to students.

Your Auxiliary's President-elect, Mrs. Charles Moloney, and I have been privileged to represent New Jersey at the State Medical Auxiliary conventions in Virginia, West Virginia, Pennsylvania, and New York.

Our Legislation Chairman, Mrs. Frank Campo, is arranging what has become an annual trip to Washington, D.C., where we meet with our respective legislators. This year the trip will be April 17-18, 1985. Auxiliary members from neighboring states have expressed interest in joining us.

Keep thinking "Convention" in Lancaster, Pennsylvania, May 3-5, 1985. Mrs. Joseph Basralian and Mrs. John Holdcraft are working hard to make it a winner. Golf, tennis, and bridge tournaments will be held—come join us at Americana Host Farm.

The holiday season is upon us. Best wishes for a happy one!

Current Legislation

The Board of Trustees of the Medical Society of New Jersey approved the recommended positions on the following bills of medical interest, unless noted otherwise:

S-331-Lynch—Medicaid. Requires Medicaid to provide treatment for patients that are drug abusers. The treatment must be prescribed by a physician and provided in an approved facility. **Approved** (Doctor Lehr voted in the negative and asked to be so recorded).

S-1177-Gagliano—Jury Duty. Revises the jury selection system in New Jersey. Every citizen of the United States over the age of 18 and residing in New Jersey will be placed on the pool list. Existing exemptions for police, fire, health care personnel, etc., are repealed. **Disapproved,** because inclusion of health care professionals will cause unwarranted disruption in the provision of health care services to the ill and injured residents of New Jersey.

S-1287-Gagliano—Criminal Responsibility. Abolishes insanity as a defense. Allows mental health to be considered a mitigating factor in sentencing. **Action Deferred,** pending further information from the Council on Mental Health.

S-1295-Lynch—Athletic Trainers. Licenses athletic trainers through the State Board of Medical Examiners. They can provide physical treatment modalities ordered by a licensed physician. They must be employed by a school, college, university, or professional team. **No action.**

S-1342-Lesniak—Pesticides. Regulates the manufacture, use, and disposal of pesticides. Authorizes and directs the Department of Environmental Protection to prevent the contamination of water supplies. **Approved.**

S-1504-Graves—Lead Poisoning (same as A-1048). Requires the Department of Health to screen high-risk children between the ages of one to five years for lead poisoning. A similar bill passed the Legislature last year, but was con-

ditionally vetoed by the Governor. His concerns have been addressed in S-1504. **Approved.**

S-1513-Codey—Medicaid. Prohibits administrators of nursing homes from requiring incoming patients or their families to sign agreements to stay as private patients when they are eligible as Medicaid patients. Also prohibits the divesting of assets within 24 months of an application for Medicaid eligibility. **Disapproved,** Medicaid payments to hospitals are based on the same rates as those paid by, or on behalf of, all other patients. Medicaid payments to nursing homes are below the rates fairly charged to other patients. As a result of Medicaid patients not paying a fair rate, all other patients are charged more. Medicaid patients and families with assets should make a contribution to a fair rate.

S-1515-Codey—Nursing Homes. Prohibits nursing homes from refusing to accept Medicaid recipients if their occupancy level is below the statewide average as calculated by the Commissioner of Human Services. Exceptions can be granted based upon bed capacity and financial status of the institution. **No Action.**

S-1534-Cowan—Antitrust Immunity. Expands immunity from antitrust suits to licensing boards to include their actions regarding admittance to a profession, suspension, and revocation of licenses. **Disapproved,** because members of licensing boards should continue to be legally responsible for their decisions and actions. (Drs. Lehr, Allen, Salerno, and Sachs voted for an upgraded position of Active Opposition and requested to be so recorded.)

S-1557-Russo—Wrongful Death of Minors-Damages. Permits the awarding of compensatory damages in cases of wrongful death of minors. There would be a limitation of $100,000. (Current law limits these awards to pecuniary loss, together with established special damages.) **Disapproved,** because only damages established by proof should be subject to award. Supreme Court decisions in New Jersey have established a reasonable and workable format for awarding damages in wrongful death actions. This bill would create an unwarranted expansion and escalate the cost of casualty insurance without any benefit to the public.

S-1584-DiFrancesco—Abuse of Elderly Disabled or Incapacitated Persons. Requires every person who has reasonable cause to believe an elderly or disabled person is the victim of abuse or exploitation to report that information to the Commissioner of Human Services or his designee. **Approved.**

S-1650-Ewing—Biotechnology (same as A-1764). This bill establishes the advanced technology center in biotechnology on the adjoining campuses and under the joint governance of Rutgers, The State University, and UMDNJ. The purpose of establishing this center is to promote the development of biotechnology research, and to stimulate additional job opportunities and new business in this state. This bill implemen recommendation 1 of the report of th Governor's Commission of Science ar Technology. **Approved.**

S-1654-Ewing—Science and Tecl nology (same as A-1767). This b creates a New Jersey Commission on Sc ence and Technology in the Departmer of Commerce and Economic Develo ment. This bill implements recomme dation 38 of the report of the Governor Commission on Science and Technolog This new agency will have the respons bility for formulating long-range plar and programs for science and technolog in New Jersey. **Approved.**

S-1714-Bassano—Podiatric X-ra Technicians. Licenses podiatric x-ra technicians and allows them to take x rays of the "leg* and foot area." Thei curriculum and examination will be es tablished and conducted by the Radio logic Technology Board of Examiners (*Note: Current law limits the podiatris to the "lower leg" and foot.) **Active Op position,** this legislation is inferior t S-515 which, adequately, addresses th issue.

S-1717-Lynch—Education Bon Fund. Creates an $80 million bond fun to finance the construction of a networ of advanced technology centers at privat and public institutions of higher educa tion. **Approved.**

S-1720-Bassano—Marriage Certifi cates. Requires all female marriag license applicants under age 45 to under go rubella testing in addition t serological testing. **Conditional Ap proval,** pending amendment "that thi bill will expire in ten years."

S-1721-Bassano—Rh Testing. Re quires every physician attending a woman at the time of delivery, miscar riage, abortion, or during the prenata period to secure an Rh test. If the test is Rh negative the physician, within 24 hours of receipt of the results, shall ad vise the woman of its significance and the availability of preventive treatment **Disapproved,** as unnecessary legislation and the practice of medicine by legislation. This procedure already is being done in physicians' offices and should remain a matter within the professional judgment of the physician.

S-1756-McManimon—Acupuncture (same as A-2025). Provides that acupuncturists licensed in another state immediately shall be eligible for appointment to the Acupuncture Examining Board. **No Action** (Law c.76 (1984)).

S-1775-Orechio—Chiropractic. Allows chiropractors who are licensed to practice by written examination in any state and who have completed 4,300 classroom hours in a chiropractic school to become licensed to practice by virtue of a clinical examination. **Active Opposition,** current law (which is now within the purview of the State Board of Medical Examiners) is preferable to this legislation.

S-1828-O'Connor—Licensing of Dietitians and Dietetic Technicians (Same as A-2070). Requires the licensing of dietitians and dietetic technicians through the State Board of Dietetics.

Daily Schedule
219th Annual Meeting

May 2-5, 1985
Americana Host Farm Resort
Lancaster, Pennsylvania

Thursday, May 2, 1985
9:00 A.M.—Registration Opens
9:00 A.M.—Message Center Opens
2:00 P.M.—House of Delegates
4:00 P.M.—Reference Committees (Three Reference Committee Meetings)

Friday, May 3, 1985
7:30 A.M.—Registration Opens
9:00 A.M.—House of Delegates (election)
9:00 A.M.—Message Center and Exhibits Open
12:00 NOON—Golden Merit Award Ceremony Followed by Reception
2:30 P.M.—Reference Committees (Three Reference Committee Meetings)
5:00 P.M.—JEMPAC Political Forum
5:45 P.M.—JEMPAC Wine and Cheese Reception

Saturday, May 4, 1985
8:00 A.M.—Registration Opens
8:30 A.M.—House of Delegates
9:00 A.M.—Message Center and Exhibits Open
1:30 P.M.—House of Delegates
6:30 P.M.—Inaugural Reception followed by Inaugural Dinner

Sunday, May 5, 1985
8:00 A.M.—Registration Opens
9:00 A.M.—Message Center and Exhibits Open
9:00 A.M.—Program of Major Interest to Physicians
12 NOON—Luncheons and Board of Trustees' Meeting

ietetics is defined as the application of ne principles of the science of food and utrition for the development and mangement of nutrition services to attain nd maintain health. It includes evalution and consultation. **Approved.**

S-1839-Dalton—Guardianship. mends existing law to allow a psychologist to supply evidence of a need for uardianship of a minor who is in the ustody of the Division of Mental Reardation. **Active Opposition,** decisions f this nature should be made under the upervision of a psychiatrist, not a inical psychologist.

S-1840-Cardinale—Certificate of eed. Exempts the private practice of iedicine from the certificate of need law. **ctive Support.**

S-1846-Garibaldi—Disability. rovides that cancers caused by exosure to heat, radiation, or a known arcinogen which manifest themselves n active police and firemen are assumed o be accidental and work-related disbilities. **Active Opposition,** this legisation is an intrusion on the private practice of medicine and improperly and inorrectly produces a diagnosis by legisation.

SR-25-Cardinale—Certificate of leed. Authorizes the Senate Institutions, Health, and Welfare Committee to onduct an investigation of certain ertificate of need denials in northeast ergen County. **No Action.**

SR-45-Pallone. A Senate resolution iemorializing the Congress of the Unitd States to enact legislation to extend ndefinitely New Jersey's Medicare aiver which allows the state to set hosital rates for the Medicare and Medicaid rograms. **No Action.**

A-524-Weidel—Life-Sustaining rocedures. Provides that terminally ill atients may direct their physicians, hrough a written document, to withhold r withdraw mechanical or artificial neans to sustain or supplant vital function when those acts only artificially will rolong death. The directive shall comply vith statutory form. The physician relying upon it shall determine it complies vith the statute. **No Action** (refer to the Committee on Biomedical Ethics for reort back to the Council on Legislation t its October meeting).

A-1048-Villame—Lead Poisoning same as S-1504). Requires the Department of Health to screen high-risk children between the ages of one and five ears for lead poisoning. A similar bill assed the Legislature last year, but was onditionally vetoed by the Governor. **Approved.**

A-1438-Schwartz—Athletic Trainers. Same as S-1295 with minor differences. **lo Action.**

A-1539-Doyle—Acupuncture. Creates separate Acupuncture Examining Board with regulatory authority. **No Action.**

A-1559-Garvin—Breast Cancer-Informed Consent. Requires the Department of Health and the State Board of Medical Examiners to prepare a booklet on all aspects of the treatment of breast cancer. Attending physicians are required to distribute the book to appropriate patients and to discuss it with them. **Active Opposition,** physicians have the medical-legal obligation to secure informed consent from all their patients regardless of the condition involved. The legislature should not become involved in specific acts of medical judgment and patient information. These must be developed by science, education, and standards of practice. If codification is necessary that is a function of the appropriate regulatory agencies.

A-1677-Bryant—Medical Education. Provides for the Chancellor of Higher Education to contract with Meharry Medical College and School of Dentistry, located in Nashville, Tennessee, to export five to ten medical students and three to five dental students into each Meharry class. Admission will be solely on academic merit. Students shall come from a disadvantaged or minority background. **Disapproved,** the purpose of this bill best can be resolved by utilizing educational facilities within the state.

A-1682-Muhler—Psychiatric Review-Criminally Insame. Creates a seven person board within the Department of Human Services vested with the authority to release or continue the commitment of persons who were found incapable of standing trial or not guilty by reasons of insanity. A Superior Court judge currently makes these decisions. **Active Opposition,** this authority should remain within the jurisdiction of the Superior Court judge. The Court is more experienced in objectively evaluating the evidence presented and the needs of the individual and society in general.

A-1688-Shusted—Anatomical Gifts. Requires hospitals to ascertain, whenever possible, whether a patient has made an anatomical gift and to make that information a part of the record. **No Action.**

A-1764-Gill—Biotechnology. This bill establishes the advanced technology center in biotechnology on the adjoining campuses and under the joint governance of Rutgers, The State University, and UMDNJ. The purpose of establishing this center is to promote the development of biotechnology research, and to stimulate additional job opportunities and new business in this state. This bill implements recommendation 1 of the re-

***The Journal* of the**
Medical Society of New Jersey

presents

300 YEARS OF MEDICINE IN NEW JERSEY

September 1984

We are celebrating the history of medicine in New Jersey. This special issue illuminates the beginnings of our health care system and the growth of medical care: essays highlight those talented individuals who devoted themselves to this system, and commentaries present the development of specialized care in associated fields of medicine. Plus a special photography section highlighting three statewide exhibits.

Copies of this issue are available by sending $5.00 (check or money order) to MSNJ, Two Princess Road, Lawrenceville, NJ 08648. All MSNJ members will receive one copy of this issue.

Name _____

Address _____

_____

Enclose a $5.00 check or money order for each copy.

port of the Governor's Commission on Science and Technology. **Approved.**

A-1767-Gill—Science and Technology. This bill creates a New Jersey Commission on Science and Technology in the Department of Commerce and Economic Development. This bill implements recommendation 38 of the report of the Governor's Commission on Science and Technology. This new agency will have the responsibility for formulating long-range plans and programs for science and technology in New Jersey. **Approved.**

A-1786-Gallo—Hemophilia. Requires all hospital services contracts to include services and products rendered at home under the supervision of a state-approved hemophilia treatment center. **Approved.**

A-1787-Gallo—Hemophilia. Same as A-1786, applies to group health insurance contracts. **Approved.**

A-1788-Gallo—Hemophilia. Same as A-1787, applies to individual health insurance contracts. **Approved.**

A-1829-Otlowski—Medicaid. Prohibits families from encouraging elderly relatives to divest assets in order to become Medicaid eligible. Prohibits hospitals, nursing homes, and intermediate care facilities from receiving contributions from Medicaid eligible individuals or their families at any time. Prohibits a skilled nursing facility (SNF) or intermediate care facility (ICF) from denying admission on the basis of Medicaid coverage. (The Commissioner of Human Services may make particular exceptions based on capacity or financial condition of the facility. Prohibits the SNF and ICF from leveraging private pay status via contract prior to acceptance as a Medicaid patient. **Action Deferred,** recent amendments to the bill were not available for Council review. This bill, therefore, is referred directly to the Board of Trustees, in amended form, for their consideration and action.

A-1840-Kern—Wrongful Death. Requires that when a wrongful death settlement is "structured," the Court will determine prior to the settlement who will receive and in what proportions. **No Action.**

A-1854-Gallo—Alzheimer's Disease. Increases the legislative members on the Alzheimer's Commission to give them a majority. **No Action.**

A-1870-Garvin—Motor Vehicles. Amends existing statutes to require either belts or restraint systems for all children under ten traveling in a motor vehicle. Current law applies to children under age five. **Active Support.**

A-1881-Perun—Insurance Coverage of Organ Transplants. Requires medical service corporations to provide coverage for transplant procedures in their contracts. **No Action.**

A-1882, 1883, 1884, 1885-Perun—Organ Transplant. Requires health insurers and HMOs to cover organ transplants in their contracts. **No Action.**

A-1921-Miller—Professional Liability—Statute of Limitations. Establishes a three-year statute of limitations in tort actions against health care providers. Children would have until age 11 to bring an action for injuries prior to age 8. After age 8 they come under the three year standard. Fraud concealment and unintentional foreign bodies "toll" the statute. **Active Support.**

A-1922-Miller—Professional Liability—Affidavit of Merit. Provides that within 60 days of filing a medical malpractice complaint, the plaintiff must supply an affidavit, by a qualified expert, that reasonable cause exists to believe malpractice occurred. **Active Support.**

A-1924-McEnroe—Nurse-Midwife. Requires the Commissioner of Health to establish a nurse-midwife prenatal demonstration project at East Orange General Hospital in accordance with guidelines established by the Commissioner. **Action Deferred,** pending further information from the Essex County Medical Society.

A-2070-Muhler—Licensing of Dietitians and Dietetic Technicians (same as S-1828). Requires the licensing of dietitians and dietetic technicians through the State Board of Dietetics. Dietetics is defined as the application of principles of the science of food and nutrition for the development and management of nutrition services to attain and maintain health. It includes evaluation and consultation. **Approved.**

A-2155-Otlowski-Use of Drugs by Optometrists. Permits optometrists to use topical drugs for treatment and diagnostic purposes. **Active Opposition,** optometrists are not medical doctors and therefore should not be given the mandate, via legislation, to administer drugs. If the wrong medication is prescribed, what could appear to be a simple problem could develop into destructive process of the eye in a very short period of time. The bill is short-sighted in attempting to provide lesser cost care to the general public at the expense of the quality.

AR-25-Rocco—Nonviable Human Fetuses. Requests the Commissioner of Health to vigorously educate the public, particularly young people, about the dangers of cigarette smoking. **Active Support.**

AR-62-Felice. An Assembly Resolution memorializing the Congress of the United States to enact legislation to extend to January 1, 1986, New Jersey's Medicare waiver which allows the state to set hospital rates for the Medicare and Medicaid programs. **No Action.**

Retired Lives Reserve

On July 18, 1984, Pres. Reagan signed into law the Tax Reform Bill of 1984 which included the long-awaited approval of the corporate employee benefit *Retired Lives Reserve.* This plan was endorsed by the Medical Society of New Jersey for its membership in 1981.

Retired Lives Reserve is a tailored fringe benefit program providing permanent group term life insurance to reward select employees. The concept offers a valuable asset without the tax obligations by providing: during employment, conventional group term life insurance coverage; and at retirement, prepaid group term life insurance coverage for life.

Assuredly, this is the ultimate tax favored method of purchasing life insurance. Both the group term and reserve deposits paid by the corporation are fully deductible and are not included in the physician's gross income. Benefits under a Retired Lives Reserve plan are not subject to income tax, gift tax, or federal estate tax if properly arranged.

Initially, Retired Lives Reserve was conceived over 18 years ago for large public corporations, but was made available a few years ago to closely held professional corporations. After 26 private letter rulings by the IRS approving the Retired Lives Reserve concept, it finally has become the "law of the land."

Physician advantages are:

1. Physician contribution: None.
2. Provides postretirement insurance coverage that is income tax free, gift tax-free, and federal estate tax-free.
3. Allows physicians to designate beneficiary and assign ownership rights to suit individual needs.
4. Lifetime death benefits.
5. No cost after retirement.
6. Death benefits continue after retirement regardless of status of the corporation.

Corporation advantages are:

1. Provides impressive coverage to benefit key people.
2. Total deposit paid by the corporation is tax deductible.
3. Corporation deposit ceases upon retirement.
4. Reserve investment fund grows on an income tax-free basis.
5. Plan cannot be cancelled by the insurance company.
6. Stop and go provisions.
7. Simple and inexpensive to administer.

The program endorsed by the Medical Society of New Jersey has earned an average of 14.79 percent tax-free over the past five years. For more information about the Medical Society of New Jersey plan call or write Joseph C. Lucci, Director of Medical and Insurance Affairs, 2 Princess Road, Lawrenceville, NJ 08648, (609) 896-1766.

William P. Squire, Jr.
President of Employee Benefits of America, Inc., Washington, D.C.

New Members

The Journal of the Medical Society of New Jersey would like to welcome the following new members:

Atlantic County
Marianito O. Asperilla, M.D., Atlantic City
Eduardo A. Dijamco, M.D., Atlantic City
Barry D. Glasser, M.D., Atlantic City
Robert M. Goldberg, M.D., Somers Point
Stuart A. Sackstein, M.D., Atlantic City

Bergen County
James J. Cappola, M.D., Englewood
Micael A. DeGennaro, M.D., Dumont
Gary J. Savatsky, M.D., Hackensack

Burlington County
Anthony D. Dippolito, M.D., Mount Holly
Michael S. Entmacher, M.D., Moorestown
Martin B. Laufe, M.D., Mount Laurel
John Francis McGrail, M.D., Mount Holly
Richard S. Murray, M.D., Mount Holly
Alan S. Penziner, M.D., Willingboro
David A. Popper, M.D., Mount Holly
Phyllis J. Shetty, M.D., Mount Laurel
Martin S. Topiel, M.D., Mount Holly

Camden County
Thomas J. O'Dowd, M.D., Cherry Hill

Essex County
Reynald Altema, M.D., Newark
Charles S. Goldberg, M.D., Montclair
Leonard Jaffe, M.D., Bayonne
Philip E. Kline, M.D., Newark
Stanley J. Robboy, M.D., Newark

Gloucester County
Michael J. Denner, M.D., Woodbury

Hudson County
William P. Boyan, M.D.
George L. Colon, M.D., Jersey City
Dominick Condo, M.D., Jersey City
Keith A. Gresham, M.D., Jersey City
Patrick J. McGovern, Jr., M.D., Jersey City
Sooksan Traisakwatana, M.D., Jersey City

Hunterdon County
Joel R.L. Ehrenkranz, M.D. Morristown

Mercer County
Donna L. Brosbe, M.D., Trenton
Colleen A. Cooper, M.D., Trenton
Anil S. Deshpande, M.D., Trenton
Ernest E. Dorflinger, M.D., Trenton
Marcella M. Frank, M.D., Cherry Hill
Gary A. Karpf, M.D., Princeton
Charles S. Kososky, M.D., Trenton
Robert L. Moser, M.D., Trenton
William J. Mullally, II, M.D., Trenton
Aaron A. Sporn, M.D., Trenton
Frederick M. Williams, M.D., Trenton

Monmouth County
Paul A. Caviale, M.D., Long Branch
Dale E. Edlin, M.D., Middletown
David S. Handlin, M.D., Long Branch
Bruce A. Karmel, M.D., Englishtown
Irwin E. Landau, M.D., Hazlet
Kenneth W. Ordene, M.D., Freehold
Vicente C. Suoribio, Jr., M.D., Wanamassa
Robert L. Zanni, M.D., Long Branch

Morris County
Vincent B. Adamo, M.D., Parsippany
Donald M. Chervenak, M.D., Florham Park
Philip Felig, M.D., East Hanover
Thomas G. Fruzynski, M.D., Landing
Jesse S. Greenblum, M.D., Parsippany
Bohdan E. Halibey, M.D., Succasunna
Judith L. Magi, M.D., Florham Park
Lawrence C. Swayne, M.D., Morristown

Passaic County
Kishore K. Ahuja, M.D., Paterson
Henry H. Balzani, M.D., Clifton
Francis A. D'Urso, M.D., Hawthorne
Arnold Olefson, M.D., Wayne
Tae Y. Park, M.D., Clifton
Rafael D. Pereira, M.D., Passaic
Steven H. Ressler, M.D., Saddle Brook
Frederic E. Wien, M.D., Paterson
Parvin A. Zisman, M.D., Hewitt

Somerset County
Lee A. Balaklaw, M.D., Somerset

Union County
Robert J. Bercik, M.D., Rahway
Sanford Fineman, M.D., Union
Luis E. Garcia, M.D., Elizabeth
Steven J. Kalamaras, M.D., Elizabeth
Douglas J. Pravda, M.D., Kenilworth
John F. Vigorita, M.D., Summit

The *Journal* of the Medical Society of New Jersey
announces the reprinting of the

WILLIAM CARLOS WILLIAMS COMMEMORATIVE ISSUE

September, 1983

Honoring the 100th anniversary of the birth of New Jersey's prize-winning poet and physician. Included in this handsomely illustrated, full-color issue will be original articles by persons close to William Carlos Williams, artwork from his social and intellectual circle, and samples of his finest writings.

Copies of this special issue are available by sending $5.00 for each (check or money order) to MSNJ, Two Princess Road, Lawrenceville, NJ 08648.

Please send a copy of the **William Carlos Williams Commemorative Issue** to:

_____

_____

_____

Enclose a $5.00 check or money order for each copy.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY—Howard Ang, M.D., 7-29 Hegeman Ave., #3-A, Brooklyn, NY 11212. Far Eastern University 1976. Group or partnership. Available January 1985.

DERMATOLOGY—Catherine A. Nordby, M.D., 871 Beaconsfield, Grosse Pointe Park, MI 48230. St. Louis 1980. Board eligible. Specialty or multispecialty group. Available July 1985.

EMERGENCY MEDICINE—Gerard B. Martin, M.D., 871 Beaconsfield, Grosse Pointe Park, MI 48230. St. Louis 1980. Board eligible. Teaching hospital with emergency medicine residency or trauma center with research potential. Available July 1985.

FAMILY MEDICINE—Mary F. Campagnolo, M.D., 10 Overlook Rd., Apt. 5-E, Summit, NJ 07901. George Washington University 1982. Board eligible. Group or partnership. Available July 1985.

Cary A. Davidson, M.D., 100B Finderne Ave., Bridgewater, NJ 08807. SUNY-Upstate 1982. Board eligible. Rural or suburban practice, family practice, solo, group. Available July 1985.

GASTROENTEROLOGY—Ronald J. Cirillo, M.D., 7 Sandpiper Dr., Voorhees, NJ 08043. Guadalajara (Mexico) 1978. Also internal medicine. Board eligible (IM). Any type practice. Available July 1985.

Kenneth Russell Feuer, M.D., 3120 Parkway, Cheverly, MD 20785. Baylor 1980. Also internal medicine. Board certified (IM). Available July 1985.

Henry J. Katz, M.D., 20 Waterside Plaza, New York, NY 10010. Albany Medical College 1980. Board certified (IM). Group or partnership. Available.

Steven M. Samuels, M.D., 4908 David Court, Cincinnati, OH 45215. Louvain (Belgium) 1980. Also internal medicine. Board certified (IM). Group or partnership. Available July 1985.

Eliot H. Zimbalist, M.D., 430 East 67 St., Apt. 12F, New York, NY 10021. Mt. Sinai 1980. Also internal medicine. Board certified (IM). Group, partnership, multispecialty. Available July 1985.

INTERNAL MEDICINE—David M. Breidbart, M.D., 50 Hillpark Ave., Apt. 1-R, Great Neck, NY 11021. SUNY-Downstate 1979. Also pulmonary medicine. Board certified (IM); board eligible (PM). Pulmonary, pulmonary/internal medicine, multispecialty group. Available July 1985.

Ronald J. Cirillo, M.D., 7 Sandpiper Dr., Voorhees, NJ 08043. Guadalaja (Mexico) 1978. Subspecialty, gast enterology. Board eligible. Any ty practice. Available July 1985.

Kenneth Russell Feuer, M.D., 31 Parkway, Cheverly, MD 20785. Bayl 1980. Also, gastroenterology. Boa certified. Available July 1985.

Cory Krueger, M.D., 2301 Woodwa St., Apt. C-12, Philadelphia, PA 191 Rutgers 1982. Board eligible. Group partnership. Available July 1985.

Phillip A. Lecso, M.D., 5138 Regen Dr., Toledo, OH 43615. Medical Colle of Ohio 1982. Board eligible. Sing multispecialty group, partnershi Available July 1985.

Dominic Mazzocchi, M.D., 1231 89th St., Brooklyn, NY 11236. Puer Rico 1981. Board eligible. Group partnership. Available January 198

Gianfranco Umberto Meduri, M.D., 4 East 67 St., Apt. 9C, New York, N 10021. Padua (Italy) 1977. Als pulmonary. Board certified (IM Group, academic, industrial. Availab August 1985.

Richard Narvaez, M.D., 516 Berkley R Narberth, PA 19072. Temple 198 Group, partnership, HMO, solo. Ava able July 1985.

Steven M. Samuels, M.D., 4908 Davi Court, Cincinnati, OH 45215. Louva (Belgium) 1980. Subspecialt gastroenterology. Board certifie Group or partnership. Available Ju 1985.

Jerrold P. Schwartz, M.D., 69 Gold S Apt. 12-C, New York, NY 10038. Dijo (France) 1982. Group, clinic, hospita based, long-term care. Available Ju 1985.

Virod K. Shah, M.D., 345 Watkins Lan Battle Creek, MI 49017. M.P. Sha (India) 1975. Board eligible. Any typ practice. Available.

Sarajane Stirling, M.D., 2329 Lombar St., Philadelphia, PA 19146. SUNY-Up state 1982. Board eligible. Group o partnership. Available July 1985.

Robert L. Werner, D.O., 148 Reservoi Rd., Parsippany, NJ 07054. UMDNJ NJSOM 1981. Board eligible. Solo o partnership. Available July 1985.

Lewis B. Zimet, M.D., 4313 Carambol Circle South, Coconut Creek, F 33066. Far Eastern (Philippines) 1981 Board eligible. Solo, group, partner ship, industrial, or hospital-based Available.

OBSTETRICS/GYNECOLOGY—Nissim Contente, M.D., 7300 Cedar Post Rd. Apt. 10E, Liverpool, NY. Guadalajara (Mexico) 1979. Board eligible. Group o partnership. Available July 1985.

Amnon Fein, M.D., 223 East Ave., Apt 6B, Syracuse, NY 13224. Guadalajara (Mexico) 1980. Group or partnership Available July 1985.

OPHTHALMOLOGY—George R. Coar M.D., 3245 Beechwood Blvd., Apt. C-11 Pittsburgh, PA. Jefferson 1981. Board eligible. Group, partnership, solo. Avail able July 1985.

MEDICAL SOCIETY OF NEW JERSEY 1985 ANNUAL MEETING

The Medical Society of New Jersey will be conducting its 219th Annual Meeting, May 2 through May 5, 1985, at the Americana Host Farm Resort, in Lancaster, Pennsylvania.

You can plan your arrival for Thursday, May 2nd with a Sunday, May 5th departure.

There will be 500 rooms available at Host Farm Resort and an additional 100 rooms available in the immediate area.

The Hotel will maintain a shuttle bus service to and from the Host Farm Building and the Host Corral Building.

This Annual Meeting will have total exclusivity of all function rooms, dining rooms, golf and tennis facilities, entertainment, health clubs, swimming pools, two miles of bicycle and jogging trails, handball, etc.

Sightseeing and factory outlet shopping here in the beautiful Pennsylvania Dutch Country will be very appealing.

GET YOUR RESERVATION IN EARLY

Peter J. Famiglietti, M.D., Box 76, R.D. #5, Danville, PA 17821. University of Connecticut 1981. Board eligible. Group or partnership. Available July 1985.

Barry N. Shaklan, M.D., 6207 Blackberry Lane, Dallas, TX 75248. Seton Hall 1961. Board certified. Available.

ATHOLOGY—Steven P. Katz, M.D., 9634 S. Karlov Ave., Oak Lawn, IL 60453. Nebraska 1972. Board certified (PA and CLIN). Hospital or group. Available on one month's notice.

EDIATRICS—Charles H. Geneslaw, M.D., 8372 Loveridge Ct., Richmond, VA 23229. UMDNJ 1982. Partnership. Available July 1985.

Suhaila Siddiqi Hussain, M.D., 104 Running Brook Rd. East, Ewing, NJ 08638. Baghdad (Iraq) 1979. Board eligible. Group, partnership, solo. Available.

Nellie Novak, M.D., 1015 West Cherry Hill Apts., Cherry Hill, NJ 08002. Sverdlovsk (USSR) 1974. Board eligible. Group, partnership, HMO. Available July 1985.

ULMONARY MEDICINE—David M. Breidbart, M.D., 50 Hillpark Ave., Apt. 1-R, Great Neck, NY 11021. SUNY-Downstate. Also, internal medicine. Board eligible (PM); board certified (IM). Pulmonary, pulmonary/internal medicine, multispecialty group. Available July 1985.

Gianfranco Umberto Meduri, M.D., 430 East 67 St., Apt 9C, New York, NY 10021. Padua (Italy) 1977. Also, internal medicine. Board certified (IM). Group, academic, industrial. Available August 1985.

URGERY—Victor P. Bruno, M.D., 702 Fordham Rd., Bala Cynwyd, PA 19004. Georgetown 1978. Board eligible. Group or partnership. Available May 1986.

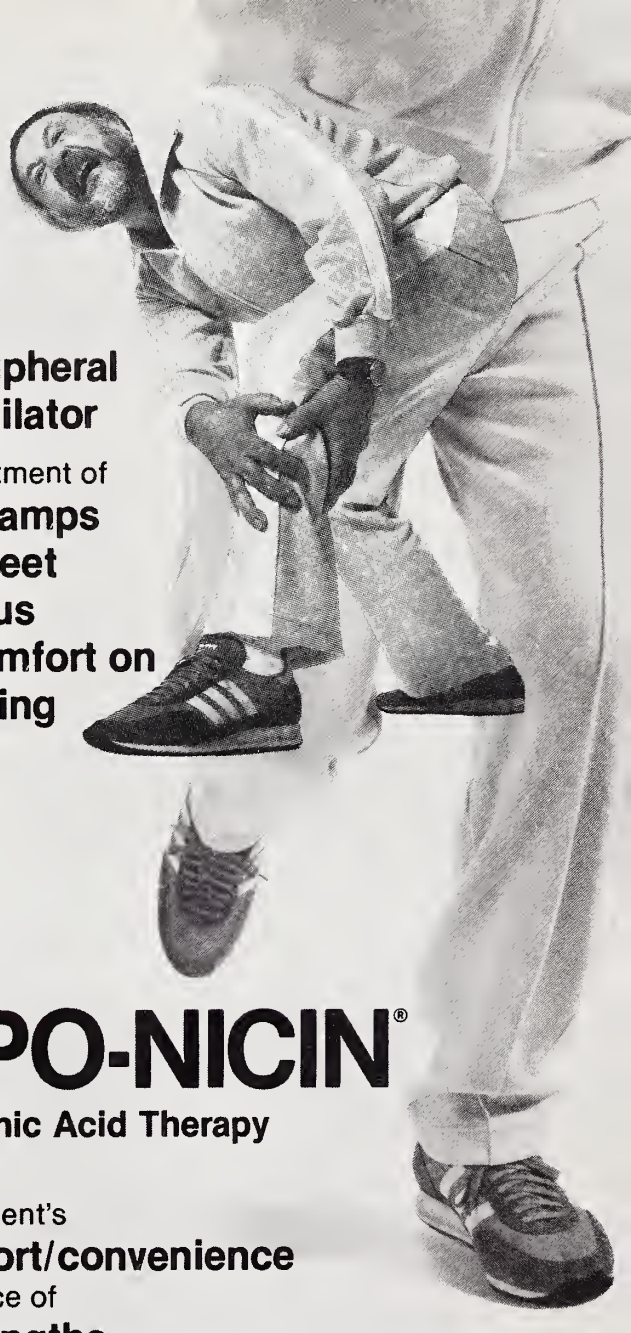
Daniel M. Goldman, M.D., 3450 Wayne Ave., Apt. 19-S, Bronx, NY 10467. Also, vascular surgery. Board eligible. Partnership or single specialty group. Available July 1985.

David A. Guthrie, M.D., 3130 Heathstead Pl., Charlotte, NC 28210. West Virginia 1978. Also, vascular surgery. Board eligible. Group or partnership. Available July 1985.

URGERY, VASCULAR—Daniel M. Goldman, M.D., 3450 Wayne Ave., Apt. 19-S, Bronx, NY 10467. Also, general surgery. Board eligible. Partnership or single specialty group. Available July 1985.

David A. Guthrie, M.D., 3130 Heathstead Pl., Charlotte, NC 28210. West Virginia 1978. Also, general surgery. Board eligible. Group or partnership. Available July 1985.

ROLOGY—Richard S.D. Tushman, M.D., 519 Vantage Pl., Richmond, VA 23236, Cornell 1980. Board eligible. Available July 1985.



A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release
LIPO-NICIN®/300 mg.

Each time-release capsule contains:
Nicotinic Acid .....300 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release
LIPO-NICIN®/250 mg.

Each yellow tablet contains:
Nicotinic Acid .....250 mg.
Niacinamide .....75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide .....75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

1984-1985 MSNJ
LIAISON REPRESENTATIVES

Academy of Medicine of New Jersey
(1) Board of Trustees/Liaison Committee
(Liaison requested by Academy—June 19, 1966)

Alfred A. Alessi, M.D., ... Hackensack
Arthur Bernstein, M.D., ... South Orange
Sherman Garrison, M.D., ... Bridgeton

(2) Postgraduate Medical Education Study Committee
(Representation requested by Academy—November 15, 1964)

Edwin W. Messey, M.D., Chairman, Committee on Medical Education ..... Willingboro
Stephen F. Wang, M.D., Member, Committee on Medical Education ..... Morristown

Agent Orange Commission, New Jersey
(Established by Governor—March 1980)

Laura E. Morrow, M.D. ..... Passaic

AMA-Education Research Foundation
(Liaison requested, by AMA—October 7, 1951)

David Greifinger, M.D., Chairman, Committee on Medical Student Loan Fund ..... Belleville

Archivist-Historian
(Appointment requested by the Medical History Society of New Jersey—April 1982)

Morris H. Saffron, M.D. ..... New York, NY

Audit Review Committee (1983-1984)
(Appointed annually to review previous year's audit)

Ralph J. Fioretti, M.D., President-Elect, Chairman ..... Rochelle Park
Joel S. Cherashore, M.D. ..... Nutley
Douglas M. Costabile, M.D. ..... Murray Hill
Edwin W. Messey, M.D. ..... Willingboro
Edward A. Schauer, M.D.,First Vice-President ..... Farmingdale
Paul J. Hirsch, M.D., Treasurer, Consultant ... Bridgewater
Harry M. Carnes, M.D., Chairman, Committee on Finance and Budget ..... Audubon
Palma E. Formica, M.D., Vice-Chairman, Committee on Finance and Budget ..... Old Bridge

Blindness, New Jersey Society To Prevent
(Requested by the Society for the Prevention of Blindness—March 19, 1978)

Marc L. Engel, M.D., Chairman, Committee on Conservation of Vision ..... Holmdel

Blood Bank Association, New Jersey
(Liaison requested by New Jersey Blood Bank Association—April 25, 1969)

Frank Campo, M.D. ..... Trenton

Blood Banking Task Force for New Jersey
(University of Medicine and Dentistry of New Jersey—Octob
1981)

Frank Campo, M.D. ..... Trent

**Blue Cross-Blue Shield Plans of New Jersey, Permane
Committee on**
(Appointment of Committee requested by MSP—April
1960)

Frank Y. Watson, M.D., President ..... Glen Ri
Vincent A. Maressa, Executive Director ..... Lawrencev
Equal representation from:
Medical-Surgical Plan of New Jersey
Hospital Service Plan of New Jersey
New Jersey Hospital Association

Commissioner's Physician Advisory Committee
(Representation requested by State Commissioner of Heal
to assist in the Diagnosis Related Group (DRG) co
cept—June 1977)

Frank Y. Watson, M.D., President* ..... Glen Rid
*Douglas M. Costabile, M.D., Murray Hill, designated as Pre
dent's representative for 1984-1985.

Diabetes Coordinating Council
(Representation requested by Department of Health
November 10, 1980)

Arthur Krosnick, M.D. ..... Trento

DRG Position, Ad Hoc Committee on Presentation of MSN
(Established by Board of Trustees—December 19, 1982)

Alfred A. Alessi, M.D., Co-Chairman ..... Hackensac
Frank J. Primich, M.D., Co-Chairman ..... West New Yo
Stanley S. Bergen, Jr., M.D. ..... Newar
John P. Capelli, M.D. ..... Haddonfie
James E. George, M.D., J.D. ..... Woodbu
Edwin W. Messey, M.D. ..... Willingbo
Myles C. Morrison, Jr., M.D. ..... Morristow
Gerald H. Rozan, M.D. ..... Wayn
Howard D. Slobodien, M.D. ..... Metuche

**Drug and Alcohol Problems, Statewide Committee To Assi
Local School Districts with**
(Representation requested by Department of Education, R
gional Curriculum Services Unit-South—June 5, 1984)

Ed Reading, M.Div. ..... Lawrencevil

Education, State Department of
(Liaison requested by the Assistant Commissioner of Educa
tion—September 21, 1958)

Glenn P. Lambert, M.D., Chairman, Special Committee on Child Health ..... Flemingto

nergency Medical Personnel and Hospitals, Division on omen Training Program for
epresentation requested by Department of Community Affairs, Division on Women—August 2, 1984)

dolf E. Schwaeble, M.D. ..... Mendham

xecutive Committee
rovided in the Bylaws, Chapter III (c))

ank Y. Watson, M.D., President, Chairman ... Glen Ridge
alph J. Fioretti, M.D., President-Elect ..... Rochelle Park
dward A. Schauer, M.D., First Vice-President ..... Farmingdale
arry M. Carnes, M.D., Second Vice-President .... Audubon
exander D. Kovacs, M.D., Immediate Past-President ..... Scotch Plains
rthur Bernstein, M.D., Secretary, Consultant ..... South Orange
aul J. Hirsch, M.D., Treasurer, Consultant ... Bridgewater

raduate Medical Education, Advisory Council on
epresentation requested by UMDNJ—1979)

dwin W. Messey, M.D. ..... Willingboro

ealth Care Administration Board
epresentative appointed by MSNJ—1976 and July 1983)

dward A. Schauer, M.D. ..... Farmingdale
Ronald Rouse, MSNJ Staff Member ..... Lawrenceville

ealth Issues, Commissioner's Special Committee on
epresentation requested by Commissioner of Health—July 983)

ouglas M. Costabile, M.D. ..... Murray Hill
ank Campo, M.D., Alternate ..... Trenton

ealth Maintenance Organization Projects, Advisory ommittee To Participate in the Review of
ecommended to Executive Director, State Health Coordiating Council, Department of Health—1974)

enry J. Mineur, M.D. ..... Westfield

ealth Professions Education Advisory Council
epresentative requested by Department of Higher Education—1976)

illiam J. D'Elia, M.D. ..... Spring Lake

ealth Sciences Group, New Jersey
lembership requested by the Group—January 19, 1975)

dward G. Bourns, M.D. ..... Jamesburg
aul J. Hirsch, M.D., Treasurer ..... Bridgewater
ernard A. Rineberg, M.D. ..... New Brunswick

ealth Sciences Group Legislative Affairs Committee, ew Jersey
iaison requested by the Group—November 16, 1975)

ving P. Ratner, M.D., Chairman, Council on Legislation ..... Willingboro

ighway Safety Policy Advisory Council, New Jersey
lomination for appointment by Governor requested by Dictor, Department of Law and Public Safety, Division of otor Vehicles—March 19, 1984)

artin E. Johnson ..... Lawrenceville*
*Appointment pending

ospital Association, New Jersey
iaison established at request of New Jersey Hospital Association—December 17, 1967)

ank Y. Watson, M.D. ..... Glen Ridge

EMPAC, Conference Committee with
stablished at request of JEMPAC—June 25, 1967

ving P. Ratner, M.D., Chairman, Council on Legislation ..... Willingboro
oseph W. Fleisher, M.D., Chairman, Council on Medical Service ..... Bayonne
arry M. Carnes, M.D., Second Vice-President .... Audubon

Legislation

(1) Federal Keymen (Mechanism established by MSNJ—April 4, 1954, to serve as official intermediaries between MSNJ and the federal legislators): 14 Congressional District Keymen and 2 Senatorial Keymen.
(2) State Keymen (Mechanism established by MSNJ—July 13, 1952): Keyman in 40 legislative districts/21 component societies.

Medical Assistance Advisory Council
(At the request of the New Jersey Department of Human Services—1980)

Thomas S. Bellavia, M.D. ..... Hasbrouck Heights*
*Appointment pending

Medical Assistants, State of New Jersey, Inc., American Association of
(Liaison requested by Association—September 15, 1963)

Giovanni Lima, M.D. ..... Kearny

Medical Liaison Committees
(High-level conference groups for discussion and consideration of items of mutual interest)

Frank Y. Watson, M.D., President ..... Glen Ridge
Ralph J. Fioretti, M.D., President-Elect ..... Rochelle Park
Edward A. Schauer, M.D., First Vice-President ..... Farmingdale
Harry M. Carnes, M.D., Second Vice-President .... Audubon
Alexander D. Kovacs, M.D., Immediate Past President ..... Scotch Plains
Arthur Bernstein, M.D., Secretary ..... South Orange
Paul J. Hirsch, M.D., Treasurer ..... Bridgewater
Vincent A. Maressa, Executive Director ..... Lawrenceville

(1) Medical-Dental
(Liaison requested by the Dental Society—June 10, 1951)
(2) Medical-Hospital
(Liaison established by MSNJ—October 25, 1953)
(3) Medical-Legal
(Liaison established by MSNJ—October 25, 1953)
(4) Medical-Nursing
(Liaison established by MSNJ—April 4, 1954)
(5) Medical-Osteopathic
(Liaison requested by Osteopathic Association—September 17, 1961)
(6) Medical-Pharmaceutical
(Liaison established by MSNJ—July 26, 1953)

Mental Retardation, Governor's Council on the Prevention of
(Appointed by Governor—June 22, 1984)

Stanley S. Bergen, Jr., M.D. ..... Newark

Middlesex County Tercentennial—300 Years of Medicine Exhibit
(Liaison requested by Middlesex County—November 21, 1982)

Arthur Krosnick, M.D. ..... Trenton
Morris H. Saffron, M.D. ..... New York, NY

Peer Review Organization of New Jersey, Inc., Federation for
(Representation on Board of the Federation requested—June 1984)

Myles C. Morrison, Jr., M.D. ..... Morristown

Pharmaceutical Assistance to the Aged and Disabled Advisory Council
(Appointed by Commissioner of the Department of Human Services—physician representation requested by Division of Medical Assistance—December 19, 1980)

Frank J. Malta, M.D. ..... Toms River

Pharmacopeial Convention, The United States
(MSNJ invited to appoint a delegate to serve—August 1980)

Frank J. Malta, M.D. ..... Toms River

Physician Jury Service, Ad Hoc Committee on
(Appointed by President, pursuant to resolution adopted by 1983 House of Delegates)

L. Arne Skilbred, M.D., Chairman ..... Glen Ridge
John J. Crosby, Jr., M.D. ..... Jersey City
Howard H. Lehr, M.D. ..... Fanwood
Irving P. Ratner, M.D. ..... Willingboro
Bernard A. Rineberg, M.D. ..... New Brunswick

Poison Information and Education System, Advisory Board to New Jersey
(Representation requested by Department of Health—January 21, 1983)

Rudolf E. Schwaeble, M.D. ..... Mendham

Prescription Abuse Avoidance Committee
(Representation requested by State Board of Medical Examiners—April 4, 1983)

David I. Canavan, M.D. ..... Lawrenceville
Daniel Greenfield, M.D. ..... Piscataway

Public Health Council, New Jersey
(Nomination for appointment by Governor to serve a seven-year term requested by Department of Health—June 1, 1984)

Henry A. Katz, M.D. ..... Morristown*
*Appointment pending

Radiation Protection, Advisory Committee on Nuclear Medicine to New Jersey Commission on
(Consultant in nuclear medicine appointed by Commission—November 20, 1966)

Henry J. Powsner, M.D. ..... Princeton

Radiation Protection, Consultant Serving New Jersey Commission on
(Nomination for appointment to Commission requested—March 17, 1963)

Frank Gingerelli, M.D. ..... Hackensack

Radiologic Technology Board of Examiners
(Agency of the Commission on Radiation Protection, Department of Environmental Protection—appointed by Governor, 1983)

Armando F. Goracci, M.D. ..... Woodbury

Resolutions, Committee on Annual Meeting
(Established by Board of Trustees July 18, 1971, to review all resolutions in advance of the Annual Meeting)

Armando F. Goracci, M.D., Chairman ..... Woodbury
Howard D. Slobodien, M.D. ..... Metuch
Alexander D. Kovacs, M.D. ..... Scotch Pla

Safety Council, New Jersey State
(Provided in Council Bylaws—1962)

Frank Y. Watson, M.D., President ..... Glen Ri
George P. Bisgeier, M.D., President's Representative, Ch man, Special Committee on Occupational Health, Work Compensation, and Rehabilitation ..... New

State Board of Medical Examiners
(Trustees designated to attend monthly meetings on a rot ing basis—per Board of Trustees December 15, 1974, a August 8, 1979)

Ralph J. Fioretti, M.D., President-Elect ..... Rochelle P
Martin E. Johnson, MSNJ Staff Member ..... Lawrencev

Statewide Health Coordinating Council (SHCC) and/or Review Committee
(Liaison established January 15, 1978—appointed by Pre dent of MSNJ)

Ralph J. Fioretti, M.D., President-Elect ..... Rochelle Pa
A. Ronald Rouse, MSNJ Staff Member ..... Lawrencev
*Appointed 1982. Doctor Fioretti will serve in this capac until he becomes President, at which time the new Seco Vice-President will serve as his replacement.

Student Association, MSNJ
(Formed—July 17, 1977)

Palma E. Formica, M.D. ..... Old Brid
L. Scott Stoney, Rutgers Medical School ..... Piscataw
Kevin Kerlin, New Jersey Medical School ..... Newa

UMDNJ, Foundation of the
(MSNJ representative appointed yearly by the Board Trustees to serve as a trustee, pursuant to the Bylaws of t Foundation—1979)

Arthur Bernstein, M.D. ..... South Oran

Widows and Orphans of Medical Men of New Jersey, T Society for the Relief of
(Liaison requested by Society—May 17, 1959)

Joseph R. Jehl, M.D. ..... Clift

Women Membership, Ad Hoc Committee on
(Established by Board of Trustees—December 19, 1982)

Carolyn W. Watson, M.D., Chairman ..... Glen Rid
Roberta G. Rubin, M.D., Vice-Chairman ... Pompton Plai
Vivian Chen, M.D. ..... Brunswi
Janet Geraghty-Deutsch, M.D. ..... Jersey Ci
Birute S. Preikstas, M.D. ..... Oakhur

ME CALENDAR

The following is a list of continuing medical education courses for the next two months. Contact the sponsoring organization for further information.

This list is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the UMDNJ. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

Jan.

12 **Dinner Meeting**
6-9 P.M.—Ramada Inn, Clark
(NJ State Society of Anesthesiologists and AMNJ)

CARDIOLOGY

Feb.

9 **Angina after Bypass Surgery**
12 noon—St. Mary's Hospital, Orange
(AMNJ)

MEDICINE

Jan.

2, 9, 16, 23, 30 **Internal Medicine Review Course**
3-6 P.M.—Overlook Hospital, Summit
(Overlook Hospital and AMNJ)

2, 9, 16, 23, 30 **Endocrine Conferences**
3:30-5 P.M.—Rotates between Newark Beth Israel Medical Center, University Hospital, United Hospitals Medical Center, Newark, and VA Medical Center, East Orange
(Endocrinology Section and AMNJ)

2, 10, 17, 24, 31 **Medical Grand Rounds**
12 noon-1 P.M.—Rutgers Medical School, Medical Education Bldg., New Brunswick
(UMDNJ and AMNJ)

2 **Medicine Morbidity and Mortality Conference**
8-9 A.M.—Rutgers Medical School, Medical Education Bldg., New Brunswick
(UMDNJ and AMNJ)

2, 10, 17, 24, 31 **Immunoregulation: Basic Concepts and Applications**
4-6 P.M.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

4, 18 **Renal Conferences in Nephrology**
4-5 P.M.—UMDNJ-Rutgers Medical School, Med. Education Bldg., Rm. 393
(Nephrology Society of NJ and AMNJ)

8 **Melanoma Precursors**
8-10 P.M.—Schering Corp., Kenilworth
(NJ Dermatological Society and AMNJ)

8 **AIDS**
8-9 A.M.—Wayne General Hospital
(AMNJ)

9 **AIDS**
1-2 P.M.—VA Hospital, Lyons
(AMNJ)

15 **Cocaine Abuse**
12 noon—St. Mary's Hospital, Orange
(AMNJ)

16 **Dermatological Conference**
6-8 P.M.—Rutgers Community Health Plan, U.S. Hwy. 1 & Rt. 18, New Brunswick
(UMDNJ-Rutgers Medical School and AMNJ)

17 **New Concepts in Digoxin Metabolism**
11 A.M.-12 noon—St. Joseph's Hospital, Paterson
(St. Joseph's Hospital and Medical Center and AMNJ)

17 **Geriatrics**
3 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

17 **Whither Multiple Sclerosis?**
5-7:30 P.M.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

24 **Visiting Professorship Program**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(Saint Barnabas Medical Center and AMNJ)

30 **Mitral Valve Prolapse**
1-2:30 P.M.—VA Medical Center, Lyons, Bldg. 93
(VA Medical Center and AMNJ)

Feb.

1, 15 **Renal Conferences in Nephrology**
4-5 P.M.—UMDNJ-Rutgers Medical School, Med. Education Bldg., Rm. 393
(Nephrology Society of NJ and AMNJ)

6, 13, 20, 27 **Endocrine Conferences**
3:30-5 P.M.—Rotates between Newark Beth Israel Medical Center, University Hospital, United Hospitals Medical Center, Newark, and VA Medical Center, Orange
(Endocrinology Section, AMNJ)

6, 13, 20, 27 **Internal Medicine Review Course**
3-6 P.M.—Overlook Hospital, Summit
(Overlook Hospital and AMNJ)

7, 14, 21, 28 **Immunoregulation: Basic Concepts and Applications**
4-6 P.M.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

12 **Virology in Dermatology**
8-10 P.M.—Schering Corporation, Kenilworth
(AMNJ)

20 **Rutgers Dermatological Conference**
6-9 P.M.—U.S. Hwy. 1 and Rt. 18, New Brunswick
(UMDNJ)

21 **The Thyroid—Its Ups and Downs**
5-7:30 P.M.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)

28 **New Treatment of Modalities and Implications of Diabetes**
11 A.M.—St. Joseph's Hospital & Medical Center, Paterson
(AMNJ)

28 **Visiting Professorship Program**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(Saint Barnabas Medical Center and AMNJ)

NEUROLOGY/PSYCHIATRY

Jan.

3 **Case Seminars and Supervision**

17 **To Improve Psychotherapeutic Techniques**
8-10 P.M.—310 Harding Dr., South Orange
(Advanced Psychiatric Study Group and AMNJ)

7 **Sexual Obsession in a 20-Year Marriage**
8:15-10:30 P.M.—111 Ridgewood Ave., Glen Ridge
(Essex Psychiatric Seminar and AMNJ)

17 **Neurology: New Treatments of Cerebrovascular Disease**
2 P.M.—John E. Runnells Hospital, Berkeley Heights
(AMNJ)

17 **Psychodynamic Art Therapy**
8-10 P.M.—Saint Barnabas Medical Center, Livingston
(NJ Psychoanalytic Society and AMNJ)

21 **Lecture Series**
8:30-10:30 P.M.—301 Broad Ave., Englewood
(NJ Psychoanalytic Society and AMNJ)

Feb.

4 **Mother-Daughter Fusion**

SIXTH ANNUAL MINIRESIDENCY IN OCCUPATIONAL MEDICINE

UNIVERSITY OF MEDICINE AND DENTISTRY OF NEW JERSEY

DEPT. OF ENVIRONMENTAL AND COMMUNITY MEDICINE
RUTGERS MEDICAL SCHOOL
PISCATAWAY, NEW JERSEY 08854

DATE:
March 11-29, 1985/15 weekdays/8:30 a.m.-4:30 p.m., 6 evening classes/6:30-8:30 p.m.

PURPOSE:
To provide a comprehensive review of key concepts in Occupational Medicine given by eminent specialists from university, government and industry. To aid in obtaining board eligibility and certification.

ACCREDITATION:
The University of Medicine and Dentistry of New Jersey-Office of Continuing Education certifies that this continuing medical education activity meets the criteria for 90 hours of credit in Category I for the Physician's Recognition Award of the American Medical Association, provided the program is completed as designed.

SUBJECTS:
Industrial Hygiene, Occupational Disease, Toxicology, Practice of Occupational Medicine, Epidemiology and Biostatistics, Ergonomics, Public Health Administration.

INQUIRIES: UMDNJ-Office of Continuing Education
Box 101, Piscataway, N.J. 08854
Patricia Reid (201) 463-4707

The Academy of Medicine of New Jersey
in cooperation with
Overlook Hospital
presents

"AN INTENSIVE REVIEW OF INTERNAL MEDICINE"

JANUARY 16, 1985 to MAY 22, 1985
(19 Successive Wednesdays)
3:00 P.M.-6:00 P.M.
at

OVERLOOK HOSPITAL
SUMMIT, NEW JERSEY

The course is designed to provide a comprehensive review contemporary concepts in Internal Medicine. It is designed f practicing internists and family practitioners. The review w also be useful for residents. Syllabus material will be di tributed during the course which will, when compiled, provi an extremely useful reference.

Course Chairman:
Michael Bernstein, M.D.

For further information on registration, faculty, and fee please contact:

The Academy of Medicine of New Jersey

Tina D'Oria
The Academy of Medicine of New Jers
Two Princess Road
Lawrenceville, NJ 08648
Phone: (609) 896-1717

LIKOFF CARDIOVASCULAR INSTITUTE

of Hahnemann Medical College & Hospital

230 N. Broad Street, Philadelphia, Pennsylvania 19102 (215) 448-8063

CARDIOLOGY UPDATE. . .

IS DESIGNED FOR THE PHYSICIAN AND PROVIDES AN INTENSIVE SURVEY OF THE CURRENT STATUS OF CLINICAL CARDIOLOGY. . .

WEDNESDAY, JANUARY 2, 1985

CARDIOMEGALY: DIFFERENTIAL DIAGNOSIS

MODERATOR: WILLIAM LIKOFF, M.D.

3:00 CASE PRESENTATION — *William S. Haaz, M.D.*

3:30 DILATED CARDIOMYOPATHY: DIFFERENTIAL DIAGNOSIS — *Stuart Snyder, M.D.*

4:00 DILATED CARDIOMYOPATHY: VASODILATOR AND INOTROPIC THERAPY—PASSION OR SKEPTICISM — *Mariell J. Likoff, M.D.*

4:30 ACUTE RECURRENT PERICARDITIS: A THERAPEUTIC CHALLENGE — *Daniel Mason, M.D.*

5:00 CARDIAC TAMPONADE: PATHOPHYSIOLOGY AND MANAGEMENT — *Harold Kay, M.D.*

LECTURE HALL "A"—2nd floor New College Building, Hahnemann University
15th and Vine Streets, Philadelphia, PA

• NO REGISTRATION FEE • NO ADVANCE REGISTRATION REQUIRED •
• CME CATEGORY I CREDITS CERTIFIED •
WINE & CHEESE SERVED FOLLOWING CONFERENCE

8:15-10:30 P.M.—9 Marquette Road, Upper Montclair
(Essex Psychiatric Seminar and AMNJ)

5 **Sleep Apnea**
1:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)

7 **Diagnosis and Management of Migraine**
11 A.M.—St. Joseph's Hospital and Medical Center, Paterson
(St. Joseph's Medical Center and AMNJ)

7 **Case Seminars**

21 8-10 P.M.—310 Harding Drive, South Orange
(Advanced Psychiatric Study Group and AMNJ)

18 **Lecture Series**
8:30-10:30 P.M.—301 Broad Ave., Englewood
(NJ Psychoanalytic Society and AMNJ)

21 **Coordination Psychiatric Treatment in the Hospital and the Community**
3 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

The Journal of the Medical Society of New Jersey

presents

300 YEARS OF MEDICINE IN NEW JERSEY

September 1984

We are celebrating the history of medicine in New Jersey. This special issue illuminates the beginnings of our health care system and the growth of medical care: essays highlight those talented individuals who devoted themselves to this system, and commentaries present the development of specialized care in associated fields of medicine. Plus a special photography section highlighting three statewide exhibits.

Copies of this issue are available by sending $5.00 (check or money order) to MSNJ, Two Princess Road, Lawrenceville, NJ 08648. All MSNJ members will receive one copy of this issue.

Name _____

Address _____

_____

Enclose a $5.00 check or money order for each copy.

28 **Third Annual Conference on Emergency Psychiatry**
Three days—Atlantic City
(O'Neill Lynch Associates, Wayne, PA)

PEDIATRICS

Jan.

11 **Extracorporeal Membrane Oxygenation for Neonatal Respiratory Failure**
8-9:30 A.M.—Overlook Hospital, Summit
(Overlook Hospital and AMNJ)

Feb.

8 **Controversies in Pediatric Nutrition**
8-9:30 A.M.—Overlook Hospital, Summit
(Overlook Hospital and AMNJ)

RADIOLOGY

Jan.

16 **Combined Modality Therapy in the Treatment of Unresectable Carcinoma of the Pancreas**
6:30-10 P.M.—The Manor, West Orange
(Radiotherapy Section and AMNJ)

17 **Multimodality Approach to Renal Disease**
7:30-10 P.M.—Saint Barnabas Medical Center, Livingston
(NJ Institute of Ultrasound in Medicine and AMNJ)

Feb.

21 **Radiology Meeting**
7:30 P.M.—Saint Barnabas Medical Center, Livingston
(Radiological Society of NJ and Diagnostic Radiology Section, AMNJ)

SURGERY

Jan.

15 **Surgical Grand Rounds**
29 7-9 A.M.—Hackensack Medical Center
(Hackensack Medical Center and AMNJ)

22 **Malignant Hyperthermia**
8-10 P.M.—Englewood Club, Englewood
(Englewood Surg. Soc. and AMNJ)

Feb.

12 **Surgical Grand Rounds**
26 7-9 A.M.—Hackensack Medical Center
(Hackensack Medical Center and AMNJ)

26 **Venous Disease and Venous Surgery**
8-10 P.M.—Englewood Club, Englewood
(Englewood Surgical Society and AMNJ)

MISCELLANEOUS

Feb.

12 **Malpractice**
12 noon—West Jersey Hospital, Camden
(AMNJ)

ACUPUNCTURE IN CLINICAL PRACTICE

N.Y. State Boards of Medicine & Dentistry 25-hour accredited seminar and workshop on the latest theories & techniques of manual & electro-acupuncture and TENS, applicable toward the 200-hour requirement for certification, will be given for licensed clinicians (with or without prior training) during the weekend of Dec. 14-16, 1984 and again the weekend of Feb. 1-3, 1985 at the Barbizon Plaza Hotel, New York City. Co-sponsored by the International College of Acupuncture & Electro-Therapeutics, its official journal, Acupuncture & Electro-Therap. Res., Int.J. (published by Pergamon Press and indexed in 15 major indexing periodicals; INDEX MEDICUS, etc.), the Heart Disease Research Foundation and the Neuroscience Dept. of Long Island College Hospital, Pharmacology Dept. of The Chicago Medical School. Also eligible for AMA/CME credit. For information, contact Y. Omura, M.D., ScD., 800 Riverside Drive (8-1), NYC 10032. Tel: (212) 781-6262 or (212) WA8-0658, or Saul Heller, M.D., Tel: (212) 838-7514.

Kirwan Financial Group, Inc.

Financial Planners
for the
Medical Profession

Investments, Pensions, Insurance, Etc.

- **Honest**
- **Sophisticated**
- **Profusely Referenced**

609-778-4388

NEW YORK FERTILITY RESEARCH FOUNDATION, INC.

For the Investigation of
Problems of Human Infertility

The Foundation provides a comple diagnostic and consultation service for i fertile couples. Investigations are co ducted by well-known specialists in co junction with consultants in the variou fields of medicine related to infertility.

The Foundation is supported by an i house modern laboratory equipped to d most tests required for diagnosis an treatment. Literature on request.

1430 Second Avenue, Suite 103
New York, N.Y. 10021
Phone: (212) 744-5500

Neuroimaging Update 1985

February 1-6, 1985

Camino Real
Puerto Vallarta, Mexico

COURSE DESCRIPTION

This conference is designed for radiologists, neurologists, neurosurgeons and other physicians with interest in various neuroimaging modalities. The program will provide a comprehensive and intensive review of the basic principles, practical application and analysis of the current imaging techniques encompassing computed tomography, digital subtraction angiography, neurointerventional procedures, neuro-sonography and nuclear magnetic resonance. Emphasis will be on the new exciting technology—N.M.R. which will be highlighted by a special session for the research and development presented by the major NMR manufacturers. In addition, daily round table discussion with the faculty members will be conducted during breakfast.

TUITION

The tuition for this course is $475.00 for physicians and $300.00 for residents in training with a letter of verification of status. **A refund of less than $50.00 will be made upon written request received prior to Dec. 15. 1984.**

ACCREDITATION

20 hours of Category I, CME by American College of Radiology.

For Further Information, Contact:

S. Howard Lee, M.D. Course Director, (201) 668-3085; 3089 for course program. J. Brown Travel Agency, Travel Coordinator, (315) 446-7600 for travel arrangements.

Price per person for "Land Arrangements" Package

Single	$785.00	Triple	$425.00
Double	$505.00	Children	$ 80.00

COURSE DIRECTOR
Seungho Howard Lee, M.D.

PROGRAM DIRECTORS
C.V.G. Krishna Rao, M.D.
Theodore Villafana, Ph.D.

FACULTY

William G. Bradley, Jr., M.D., Ph.D.
Mokhtar Gado, M.D.
Burton P. Drayer, M.D.
Seungho Howard Lee, M.D.
Thomas P. Naidich, M.D.
C.V.G. Krishna RAO, M.D.
Theodore Villafana, Ph.D.
Meredith A. Weinstein, M.D.
Charles Citrin, M.D.
Gary DeFillip, M.D.

MUHLENBERG HOSPITAL 1877

Dept. Radiology and
Medical Education
Muhlenburg Hospita
Plainfield, N.J.

Basic and Clinical Pharmacology; Current Medical Diagnosis and Treatment—1984; Current Gastroenterology; Merritt's Textbook of Neurology; The Source Book of Plastic Surgery; Symposium of Plastic and Reconstructive Surgery of the Eye and Adnexa

Basic and Clinical Pharmacology

Bertram Katzung, M.D., (ed). Los Altos, CA, Lange Medical Publications, 1984. Pp. 888. Illustrated. ($26)

Basic and Clinical Pharmacology is an excellent, concise textbook of pharmacology for students of medicine and related health sciences. Each chapter is authored by individuals with expertise in the area.

Altogether, 63 individuals have contributed to this volume, but the editor, a professor of pharmacology at the University of California, San Francisco, has attained far greater clarity and uniformity of style than are found in many multiauthored texts.

The orientation of facts and concepts presented is unmistakably clinical and is commonly organized on the basis of clinical uses rather than molecular mechanism of action. Often, chapters attempt to explain the rationale for therapy by relating the molecular actions of drugs to our current understanding of the pathophysiological basis of disease. The initial three chapters, which provide information about drug receptors, pharmacodynamics, and pharmacokinetics, notably are excellent in explaining contemporary concepts in a manner suitable for medical students. While reasonably complete and current, the information presented is not encyclopedic in scope and tends to emphasize central facts and concepts. This provides a text of manageable dimensions for an introductory course in pharmacology rather than an exhaustive reference compendium.

Bibliographies provided at the end of the chapter are thoughtfully selected, recent, and commonly provide good guidance to those seeking additional information on a particular topic. Useful appendices summarize important drug interactions, drug effects on laboratory tests, and trade name-generic name identities.

Bruce McL. Breckenridge, M.D., Ph.D.

Current Medical Diagnosis and Treatment—1984

Marcus A. Krupp, M.D., and Milton J. Chatton, M.D. (eds). Los Altos, CA, Lange Medical Publications, 1984. Pp. 1,153. ($26)

This book has become a standard item on the bookcase behind the doctor's desk. There must be several times a week we must look up a vital point quickly as the patient in question is waiting in our office.

The text has 34 chapters covering the entire field of medicine and a very good index enabling one to quickly find the topic of interest. The book is useful for a quick review of a subject in order to find the answer to one or two questions, i.e. what is the best antibiotic for otitis media in an adult; what are the key features of AIDS; and which is the best prophylactic medication against diarrhea for a traveler going to Mexico.

The book is reissued annually and written by respected experts. Many readers will disagree with points of the book because the authors strive for extreme terseness and simple facts while medical subjects often are confusing and "facts" doubtful. A small bibliography follows each topic subject and the interested reader can delve more deeply and reach his or her own conclusion among the many choices. This reviewer recommends this book for purchase and frequent use.

Norman Riegel, M.D.

Current Gastroenterology, Volume 4

Gary Gitnick (ed). New York, NY, John Wiley & Sons, 1984. Pp. 461. Illustrated. ($60)

This book represents the editor's fifth annual review of progress in gastroenterology. The first year's volume combined hepatology and gastroenterology—this now has been split into separate reviews entitled *Current Hepatology* and *Current Gastroenterology.*

This text is a multiauthored literature review and, therefore, the contents of the nine separate chapters risk reflecting the personal prejudices of the chapter author. Each chapter has been reviewed not only by the editor but also by an expert in the field, who advises the chapter author on errors of omission or unbalanced views. The authors are charged with selecting the most significant report from the literature and assessing areas of progress or change. The aim is to include important articles that further our understanding of the workings of the particular organ and help us to deal with the disorders of this organ as scientists and clinicians.

By and large, this aim has been achieved. The chapter authors will be well recognized by gastroenterologists as respected experts in their various fields. In fact, this very well may be the best review of gastroenterology that I have come across in quite some time. The book is aimed specifically for those with a solid background in gastroenterology. However, it will also be useful for someone interested in a brief update of a particular topic which is well referenced.

The book is divided into nine sections beginning with the traditional chapters on the esophagus, stomach, small intestine, colon, and pancreas. This is followed by sections on gastrointestinal hormones and gastrointestinal malignancies. The next chapter is interestingly concerned with extraintestinal manifestations of gastrointestinal disease and gastrointestinal manifestations of extraintestinal disease. Finally, the chapter on advances in gastrointestinal endoscopy is both appropriate and appreciated.

I found reading this text both

pleasurable and practical. Certainly, some chapters have more clinical relevance than others. I recommend this book to all my colleagues in gastroenterology and anyone else with an interest or background in this area.

Joel D. Levinson, M.D.

Merritt's Textbook of Neurology, Seventh Edition

Lewis P. Rowland, M.D., (ed). Philadelphia, PA, Lea & Febiger, 1984. Pp. 774. Illustrated. ($48.50)

Dr. H. Houston Merritt first published this text in 1955 and then was the sole author. It has been a standard neurology text for three decades. Dr. Merritt remained its only author until the sixth edition when he accepted some limited contributions by others. He died in 1979. His current successor as director of the neurology service at the Neurological Institute of Presbyterian Hospital, New York City, Dr. Lewis P. Rowland, now has assembled some 70 authors to compile this latest edition. Most of them were former students of the original author.

Much of Dr. Merritt's material remains, but the contributors have updated and added new material in many areas. One entirely new feature is an opening segment of 50 pages devoted to the description of symptoms of neurologic disorders such as headache, coma, dementia, weakness, and involuntary movements. That section will be most useful to students and house officers, but all physicians will profit by reading it.

The editor has woven the contributions into a very uniform fabric that is both complete and comprehensive. The effort to preserve Merritt's clear, simple, and lucid style of writing is successful, though some sentences are quite long and complex. One minor detraction is the relatively small print size, perhaps utilized to limit the overall size of the book. Presentation of this wealth of material flows smoothly, but is so extensive that probably few will read through the complete text except for beginning neurology residents. References are recent, appropriate, and kept to a reasonable number. Indexing is extensive and very usable. And, the cost of the text certainly is reasonable by today's standards.

Interns, residents, general physicians, and neurologists all will find this latest edition of a familiar text both a bargain and very useful in its new format. The late Dr. Merritt would be very proud indeed of this edition.

Stanley C. Leonberg Jr., M.D.

The Source Book of Plastic Surgery

Frank McDowell, M.D., (ed). Baltimore, MD, Williams & Wilkins, 1977. Pp. 509. Illustrated. ($50.95)

The Source Book gives a historical review of the beginnings of plastic surgery. It includes many original articles translated by distinguished modern plastic surgeons and others. The "linkage" of one historic publication to another has been done expertly with the use of editorial comments and short descriptions of the original authors.

Some emphasis has been placed on the history of rhinoplasties and the repair of cleft lip and palate. However, since most of the distinguished originators of the reconstructive procedures were outstanding general surgeons and physicians, this book should be of interest to all. Biographies of some of the great builders in the field of plastic surgery have been included at the end.

Dr. McDowell, a well-known surgeon and for many years editor of the *American Journal of Plas and Reconstructive Surgery*, has c constructed a most valuable boo that will be an addition to every su geon's library and a must for eve plastic surgeon.

Robby Meijer, M.

Third International Symposium of Plastic and Reconstructive Surgery of the Eye and Adnexa

Aston, Hornblass, Meltzer, Ree (eds). Baltimore, MD, Williams Wilkins, 1982. Pp. 362. Illustrate ($68)

The *Third International Sym posium of Plastic and Reconstru tive Surgery of the Eye and Adnex* is an authoritative and complet text on the subject of ophthalmi plastic and reconstructive surger that should appeal to a very wid range of specialists and sub specialists; this includes genera plastic surgeons, ophthalmologists ear, nose, and throat surgeons dermatologists, oral surgeons, an neurosurgeons.

The book is well organized an consists of excellent articles by rec ognized experts in their field. The subjects covered are of interest to al subspecialists, yet are combined in one text in detail. All of the sections are well written, informative, and worthwhile, but the section "Congenital Deformity of the Orbital Region" is particularly outstanding. The sections "Tumors of the Orbit," "Lacrimal Disorders," "Soft Tissue Sockets," and "Ptosis" are not as strong.

This text is strongly recommended as a reference source for any of the subspecialists who encounter patients with various problems in ophthalmic plastic and reconstructive surgery.

Joseph A. Mauriello, Jr., M.D.

Drs. Branigan; Frost; Gardner; Moeckel; Rosamilia; Silverman; Winter

)r. G.V. Branigan, Jr.

George Velesto Branigan, Jr., M.D.,)rmer director of the department of rthopedic surgery at Valley Hospi-l, Ridgewood, died on August 22, 984. Born in 1924, Dr. Branigan :eived his medical degree from eorgetown University School of ledicine, Washington, D.C., in 1948. fter completing an internship at eterans Administration Hospital, rooklyn, Dr. Branigan started a pri-ate orthopedic practice in Oakland 1 1950; after serving in the Korean Var, he moved his office to Ridge-ood in 1960. Dr. Branigan was af-liated with Ridgewood Hospital for 3 years; he also served on the staff f Paterson General Hospital. A ember of our Passiac County com-onent and of the American Dental ssociation, Dr. Branigan was a iplomate of the American Board of rthopedic Surgery and a Fellow of ie American College of Surgery.

)r. Inglis F. Frost

At the grand age of 96, Inglis olger Frost, M.D., died on July 27, 984. Born in New York, Dr. Frost eceived his medical degree from ale Medical School in 1912. After an internship at Lenox Hill Hospital, New York, he opened his own practice in New York City. In 1919, Dr. Frost moved to Morristown, where he practiced until his retirement in 1959. During his lengthy career, he was affiliated with Riverside Hospital, Boonton; General Hospital, Dover; St. Clare Hospital, Denville; and Memorial Hospital, Morristown. In 1933, Dr. Frost served as president of the Morris County Medical Society and in 1964, he served as president of the New Jersey Obstetrical and Gynecological Society. Dr. Frost was a recipient of MSNJ's Golden Merit Award in 1962, in recognition of 50 years of medical practice. Dr. Frost was a retired member of our Morris County component, a Fellow of the American College of Obstetricians and Gynecologists and of the American College of Surgeons, and a member of the American Medical Association.

Dr. Kenneth E. Gardner

Kenneth Earl Gardner, M.D., the 166th President of the Medical Society of New Jersey, died on September 12, 1984, at the age of 81. Dr. Gardner, a family practitioner from Bloomfield, served the medical community for over 50 years; during his lengthy career he was affiliated with The Mountainside Hospital, Montclair. Dr. Gardner earned his medical degree from the University of Pennsylvania Medical School in 1930 and completed postgraduate work at Philadelphia General Hospital and Columbia University. A Fellow of the American College of Chest Physicians, Dr. Gardner was a retired member of our Essex County component, and a member of the American Medical Association. Dr. Gardner served the Medical Society as a judicial councilor, and chairman of the subcommittee on public health and of the welfare committee. In 1980, Dr. Gardner received MSNJ's Golden Merit Award in recognition of his 50 years as a physician.

Dr. C. William Moeckel

Clarence William Moeckel, M.D., died in April 1984. Born in 1904, Dr. Moeckel earned his medical degree at Tufts University School of Medicine, Massachusetts, in 1928. A general surgeon, Dr. Moeckel was affiliated with The Mountainside Hospital, Montclair. He was a retired member of our Essex County component, a member of the American Medical Association, and a Fellow of the American College of Surgery.

Dr. Ralph E. Rosamilia

Ralph Elmer Rosamilia, M.D., chief of surgery at Clara Maass Medical Center, Belleville, from 1961 to 1971, died on July 27, 1984. Born in Newark in 1906, Dr. Rosamilia earned a medical degree from Syracuse University Medical School, New York, in 1932. He maintained a practice in Newark for 42 years, retiring in 1976. Dr. Rosamilia was a retired member of our Essex County component. In 1982, Dr. Rosamilia received MSNJ's Golden Merit Award honoring his 50 years as a physician.

Dr. T.M. Silverman

At the age of 92, Theodore M. Silverman, M.D., died on September 9, 1984. Born in New York City, Dr. Silverman completed his medical education at the University of Georgia Medical School in 1920. He moved to New Jersey a few years later and was affiliated with St. Elizabeth Hospital and Alexian Brothers Hospital, both in Elizabeth. Dr. Silverman was a retired member of our Somerville County component, a member of the American Medical Association, and a Fellow of the American Academy of Family Practice.

Dr. Egon W. Winter

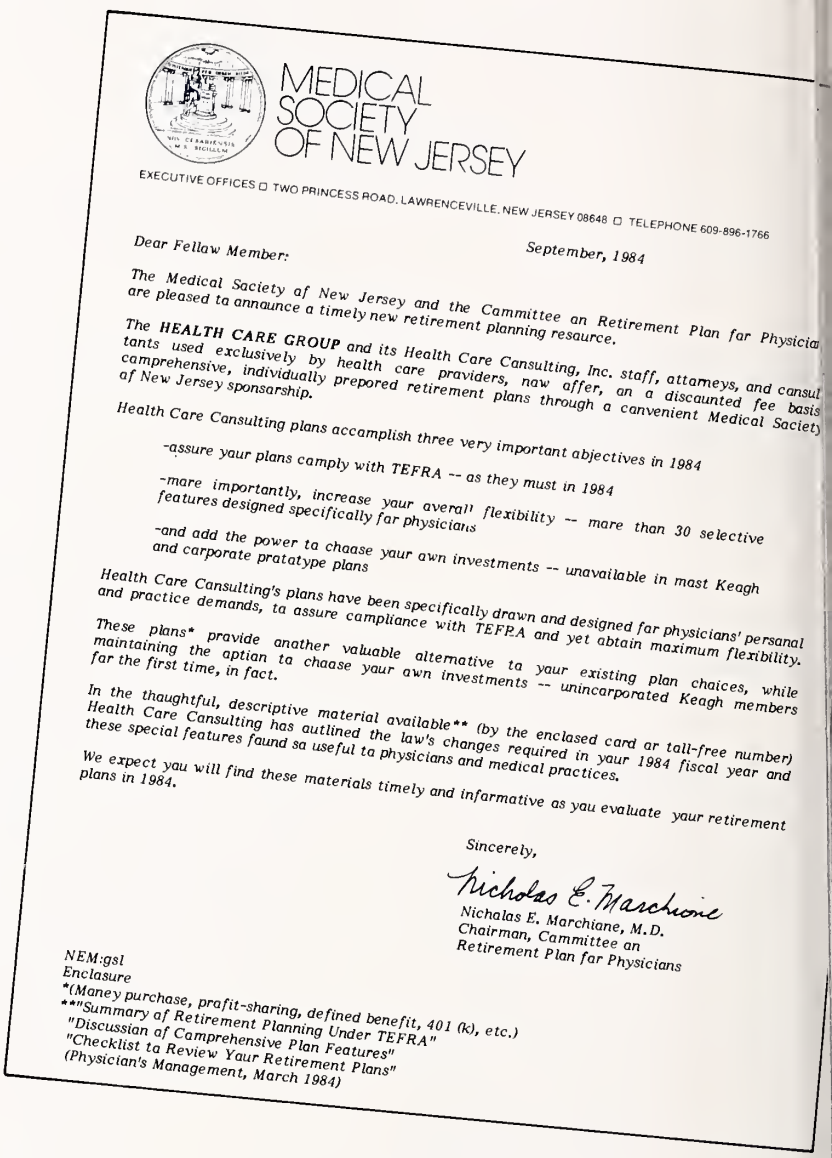
At the age of 81, Egon Werner Winter, M.D., died at home on August 24, 1984. Dr. Winter was a 1925 graduate of the University of Geisen Medical School, Germany. He emigrated to the United States in 1938 and opened a practice in Maplewood, where he served the community for 20 years. An obstetrician-gynecologist, Dr. Winter was affiliated with Saint Barnabas Medical Center, Livingston, and Newark Beth Israel Medical Center. Dr. Winter was a member of our Essex County component and of the American Medical Association, a Diplomate of the American Board of Obstetrics and Gynecology, and a Fellow of the American College of Surgeons and of the International College of Surgeons.

MSNJ Members . . .

There has never been a better time to improve your Keogh and Corporate Retirement Plans

Health Care Consulting, Inc. (HCC), primary affiliate of THE HEALTH CARE GROUP, and the Medical Society of New Jersey introduce a timely program for individually designed retirement plans—

- drafted **exclusively** for physicians' practice needs
- containing more than 30 **comprehensive,** frequently overlooked features invaluable to medical practices
- complying with **TEFRA** as you must in 1984
- allowing the same **physicians directed investment** choices for incorporated and unincorporated practices
- and providing **innovative Ongoing Plan Service**—accessibility to consultation and advice, routine amendments and our exclusive Retirement Planning Newsletter



MEDICAL SOCIETY OF NEW JERSEY

EXECUTIVE OFFICES ☐ TWO PRINCESS ROAD, LAWRENCEVILLE, NEW JERSEY 08648 ☐ TELEPHONE 609-896-1766

Dear Fellow Member: September, 1984

The Medical Society of New Jersey and the Committee on Retirement Plan for Physicians are pleased to announce a timely new retirement planning resource.

The **HEALTH CARE GROUP** and its Health Care Consulting, Inc. staff, attorneys, and consultants used exclusively by health care providers, now offer, on a discounted fee basis, comprehensive, individually prepared retirement plans through a convenient Medical Society of New Jersey sponsorship.

Health Care Consulting plans accomplish three very important objectives in 1984

-assure your plans comply with TEFRA -- as they must in 1984

-more importantly, increase your overall flexibility -- more than 30 selective features designed specifically for physicians

-and add the power to choose your own investments -- unavailable in most Keogh and corporate prototype plans

Health Care Consulting's plans have been specifically drawn and designed for physicians' personal and practice demands, to assure compliance with TEFRA and yet obtain maximum flexibility.

These plans* provide another valuable alternative to your existing plan choices, while maintaining the option to choose your own investments -- unincorporated Keogh members for the first time, in fact.

In the thoughtful, descriptive material available** (by the enclosed card or toll-free number) Health Care Consulting has outlined the law's changes required in your 1984 fiscal year and these special features found so useful to physicians and medical practices.

We expect you will find these materials timely and informative as you evaluate your retirement plans in 1984.

Sincerely,

Nicholas E. Marchione

Nicholas E. Marchione, M.D.
Chairman, Committee on
Retirement Plan for Physicians

NEM:gsl
Enclosure
*(Money purchase, profit-sharing, defined benefit, 401 (k), etc.)
**"Summary of Retirement Planning Under TEFRA"
"Discussion of Comprehensive Plan Features"
"Checklist to Review Your Retirement Plans"
(Physician's Management, March 1984)

1984 is a pivotal year for retirement planning, with the challenges presented by TEFRA and the opportunity for individually drafted plans.

HCC is extremely pleased to work with MSNJ and has prepared informative material on "**retirement planning under TEFRA,**" "**comprehensive plan features,**" and a "**checklist to review your plans,**" available by phoning toll-free or writing —

HC Health Care Group

Medical Society of New Jersey/
Health Care Consulting, Inc.
c/o THE HEALTH CARE GROUP
One Belmont Avenue
Bala Cynwyd, PA 19004
1-800-441-0737
(215) 667-2468

Name _____

Address _____

_____

Phone _____

Unincorporated ☐ Incorporated ☐ Fiscal year ends _____

INDEX: VOLUME 81
JANUARY TO DECEMBER 1984

Published monthly under the direction of the Committee on Publication

Paul J. Hirsch, M.D., *Chairman*
Dirck L. Brendlinger, M.D.
Frederick B. Cohen, M.D.
A. Olusegun Fayemi, M.D.
La Verne Fioretti
Robert M. MacMillan, M.D.
Leon G. Smith, M.D.

Arthur Krosnick, M.D., *Editor*
Geraldine R. Hutner, *Managing Editor*
Dorothy J. Griffith, *Assistant Managing Editor*

Editorial Office
Two Princess Road
Lawrenceville, NJ 08648

Society established July 23, 1766
The Journal founded September 1, 1904

ACKNOWLEDGEMENTS

The Journal acknowledges the contributions of the members of the Editorial Board (whose names are listed on the title page of each issue) for their assistance in evaluating scientific manuscripts. *The Journal* also wishes to thank the following Ad Hoc Reviewers and Book Reviewers for 1984:

AD HOC REVIEWERS

Herman Baker, Ph.D.
Salvatore Bongiovanni, M.D.
James E. George, M.D., J.D.
Robert A. Goldstone, M.D.
Bernard Grossman, M.D.
Murray Kahn, M.D.
Sidney Ketyer, M.D.
Bernard J. Koven, M.D.
Russell L. McIntyre, Th.D.
Michael L. Mund, M.D.
Peter E. Nathan, Ph.D.
Michael A. Nevins, M.D.
Max M. Novich, M.D.
James S. Todd, M.D.

BOOK REVIEWERS

Jerome Abrams, M.D.
James W. Allen, M.D.
Joseph Alpert, M.D.
Herman Baker, Ph.D.
Bruce McL. Breckenridge, M.D., Ph.D.
Solomon J. Cohen, M.D.
Samuel E. Einhorn, M.D.
Jay Eldredge, M.D.
James E. George, M.D., J.D.
Robert A. Goldstone, M.D.
Ralph S. Greco, M.D.
Gerard F. Hansen, M.D.
Christine E. Haycock, M.D.
Neil B. Horner, M.D.
Murray Kahn, M.D.
Jack R. Karel, M.D.
Avrum L. Katcher, M.D.
Sidney Ketyer, M.D.
J.F.J. Leyson, M.D.
Stanley C. Leonberg, Jr., M.D.
Joel D. Levinson, M.D.
Hugh F. Luddecke, M.D.
Robert M. MacMillan, M.D.
John S. Madara, M.D.
Dominic A. Mauriello, M.D.
Joseph A. Mauriello, Jr., M.D.
Robby Meijer, M.D.
Michael A. Nevins, M.D.
Christopher A. Papa, M.D.
Joseph Peyser, M.D.
Harry M. Poppick, M.D.
T.K. Rathmell, M.D.
Norman Riegel, M.D.
Edwin L. Rothfeld, M.D.
Manuel A. Rowen, M.D.
Mark M. Singer, M.D.
Leon G. Smith, M.D.
Robert K. Spiro, M.D.
Werner Steinberg, M.D.
Frank C. Vanore, M.D.

TABLE OF PAGES

January	1- 88	July	527- 612
February	89-160	August	613- 690
March	161-256	September	691- 822
April	257-352	October	823- 912
May	353-440	November	913-1012
June	441-526	December	1013-1122

KEY

*—Article
br—Book review
cr—Case report
cn—Clinical note
cm—Commentary
ed—Editorial
ip—Impaired physicians
le—Letter to the editor
†—Obituary
op—Opinion
ra—Review article
sp—Special article
sa—State of the art article

A

Abel, Henri E., M.D. ..... †685
Academy of Medicine Awards ed541
Academy of Medicine of New Jersey:
A Brief History—Saffron *785
Academy of Medicine of New Jersey Report—
Hirsch 71, 145, 238, 330, 424, 511, 980
Acute Radiation Pneumonitis—Silberstein; Malcolm; Braun; Fayemi cr49
Actinomycosis—Baker le995
Acutely Ill Elderly, The—Joel *655
Adverse Drug Reaction after Administration of Influenza Vaccine—Solomon; Morlino; Martucci; Ney cn573
Aesthetic Breast Surgery—Greco br344
Affuso, Philip S., M.D. cr43
Agarwal, Shashi K., M.D. *110, cr211
AIDS, Blood Banks and ed105
AIDS, Effects of, on Various Aspects of Blood Banking—Kuriyan; Muschenheim; Bianco *875
AIDS?, May a Blood Bank Refuse Donations To Prevent the Spread of—Smith; Brennan; McDonough *125
Alabama Granny Midwife—Holmes mh389
Alcoholic Cardiomyopathy—Gáspár cr557
Alewitz, Sam, Ph.D. *740
Alexander, Samuel, M.D., and the Uniform Medical Practice Act—Alexander *759
Alexander, Stewart F., M.D. *661, *759
Allen, James W., M.D. *377
Altin, Robert S., M.D. cr217
Alzheimer's Disease: The Standard Reference Book—Poppick br904
AMA Principles of Medical Ethics sa31
Amniocentesis for Prenatal Diagnosis, Midtrimester—Ghiatas *867
Amyloidosis—Varga le248
Amyloidosis and Idiopathic Hypertrophic Subaortic Stenosis, Cardiac—Daniels; Weinberg; Rangwala; Mintz *481
Androgen-Secreting Ovarian Tumors in Postmenopausal Women—Ober *878
Anesthesiologist, Professional Liability and the 285
Aneurysm of the Descending Thoracic Aorta—Agarwal; Haft; Bachik cr211
Aneurysm, Tracheoesophageal Fistula and Arteriosclerotic Aortic—Schiffman cr563
Annual Meeting bt144, bt235, bt328
Annual Review of Neuroscience, Volume 7—Leonberg br605
Annual Review of Nutrition, Volume 3—Baker br605
Anson, Leon J., M.D. ..... le903, †906
Anthony, David W., M.D. ..... †251
Anticonvulsant Agents—Geller 322
Antinori, C.H., M.D. cr393
Aorta, Aneurysm of the Descending Thoracic—Agarwal; Haft; Bachik cr211
Aortic and Mitral Valve Replacement, Part 1—Olivieri; Kostis *949
Aortic and Mitral Valve Replacement, Part 2—Olivieri; Kostis *1055
Area Health Education Center Program, The—Landay; Cohen; Reynolds *37
Arthroscopy: Diagnosis and Surgical Practice—Goldstone br605
Aspiration in Metastatic Malignant Melanoma, Fine-Needle—Rothman; Olaizola; Baker cr135
Atlas of Human Cross-Sectional Anatomy—Peyser br683
Autopsies at Newark City Hospital, 1908-1911—Sharpe mh53
Auxiliary, President of MSNJ 475
Azzara, Emanuel S., M.D. ..... †435

B

Baby Doe—Brogan le517
Baby Doe and Prognosis Committee—Katcher ed106
Bachik, Michael, M.D. cr211
Bachmann, Gloria A., M.D. *857
Baker, John, C.T. cr135
Banting, The Art of—Krosnick mh138
Banting, Sir Frederick G.—The Artist ed105
Barach, Richard L., M.D. ..... †906
Barber, George E., M.D. ..... †82
Bart, Kenneth J., M.D. *887
Basic and Clinical Endocrinology—Singer br249
Basic and Clinical Pharmacology—Breckenridge br1103
Basic, Joan: Executive Secretary—Willis le995
Benefits, Assignment of bt997
Benign Neglect, Whatever Happened to?—Nevins ... cm222
Bergen, Stanley S., Jr., M.D., Newark 70, *791
Bernardin, Ronald Maurice, M.D. ..... †1005
Bernhard, Joel A., M.D. ..... †607
Bernstein, Ellen H., M.D. ..... †435
Bianco, Celso, M.D. *875
Birnbaum, Leo, M.D. ..... †607
Births: A Survey of Patients, Out-of-Hospital—Gregory; McDonough; Maciorowski; Miller *549
Block, Paul J., M.D. ..... †435
Blood Banks and AIDS ed105
Bochenek, Joseph P., M.D. ..... †520
Book Reviews 83, 155, 249, 344, 433, 518, 605, 683, 904, 996, 1103
Brain, Microsurgical Resection of AV Malformations from Vital Areas of the—Hubschmann; Krieger *870
Brain-Damaged Persons, Rehabilitation of Cognitive Function in—Pollack; Kohn; Miller *311
Brandeis, V.T., M.D. *849
Branigan, G.V., Jr., M.D. ..... †1105
Braun, Evalynne V., M.D. cr49
Breast Cancer, Alternative Treatment—Seltzer le153
Breast Cancer: Diagnosis and Management, Volume 1—Abrams br996
Brennan, Richard, LL.D. *125
Brodman, Estelle, Ph.D *779
Brostrom, Margaret A., Ph.D. *967
Bowers, Roy A., Ph.D. *765
Buckley, Jeremiah L., M.D. ..... †520
Bump, S. Calthrop, M.D. ..... †685
Burstein, Allan, M.D. *863
Byck, Louis, M.D. ..... †685

C

Camden, The Life and Times of—Alewitz *740
Camejo, Rafael, M.D. ..... †1005
Canavan, David I., M.D. ip65, ip140, ip507
Cancer Control Coordinating Council bt235
Cancer, Impact of, on Patient and Family, The Psychological—Singer *383
Carcinoma in Children, Infantile Embryonal—Affuso; Fayemi cr43
Carcinoma, Peroral Esophageal Endoprosthesis for the Management of Incurable—Kalkay; Pancer; Derman cr45
Cardiac Amyloidosis and Idiopathic Hypertrophic Subaortic Stenosis—Daniels; Weinberg; Rangwala; Mintz *481
Cardiomyopathy, Alcoholic—Gáspár cr557
Carr, Josephus C., M.D. ..... †1005
Carras, Peter D., M.D. ..... †1005
Cassidy, Herbert E., M.D. ..... †906
Ceftriaxone, A Third Generation Cephalosporin—Johnson; Fedder; Smith *941
Cenizal, Jesus, M.D. cr131
Cephalosporin, Ceftriaxone, A Third Generation—Johnson; Fedder; Smith *941
Certificate of Need bt997
Chairman of the Board of Trustees bt589
Challenge of the Geriatric Imperative—Nevins ed631
Chanin, Israel L., M.D. ..... †251
Chico, Christine, D.O. *798
Child Find—Stromsland le604
Chinard, Francis, M.D. *661

Chiropractic Practice bt509
Chiropractic, State Board Committee on bt893
Choi, Jay Jong-Il, M.D. cn569
Cholankeril, John V., M.D. cr131
Cholecystitis, Imaging: An Approach to the Diagnosis of—Zeiger *411
Cinotti, Alfonse A., M.D. ed632
Classics of Cardiology, Volume 3—MacMillan br996
Clinical Gastroenterology: A Problem-Oriented Approach—Riegel br83
Clinical Nuclear Medicine—Horner br433
Clinician's Approach to Endocrine Problems: 45 Case Studies—Singer br683
CME Calendar 77, 149, 241, 337, 429, 515, 597, 677, 899, 991, 1099
CME Information 597
Cognitive Function in Brain-Damaged Persons—Pollack *311
Cohen, Benjamin L., D.O. *37
Cohen, Sidney L., M.D. ..... †154
Colburn, Daniel W., M.D. *849
Colitis, Radiographic Findings in Pseudomembranous—Altin cr217
Color Atlas of Life before Birth—Steinberg br155
Color Atlas of Diabetes, A—Einhorn br605
Common Skin Disorders, 2nd Edition—Papa br344
Compulsive Gambling: Your Assemblyman Speaks—Hardwick *1046
Computer System, Selection of a Medical Office—Allen *377
Computerized Tomography-Guided Percutaneous Needle Biopsy—Jewel *297
Computerizing Your Medical Office: A Guide for Physicians and Their Staff—Allen br433
Conroy Case, The—Rothberg cm229
Controversies in Dermatology—Kahn br683
Conversations in Medicine—Weisse mh576
Coronary Artery Disease in Infants and Children—Eldredge br155
Corporate Practice of Medicine bt423
Corporate Restructuring of New Jersey Hospitals bt509
Cost of Health Care, The—Courter 669
Cost of Medical Care hg465
Courter, Jim 669
Cowen, David L., M.A., Litt.D. *807
Crystal, Raymond F., M.D. *959
Current Emergency Diagnosis and Treatment—Karel br155
Current Gastroenterology, Volume 4—Levinson br1103
Current Legislation 1089
Current Medical Diagnosis and Treatment, 1984—Riegel br1103
Current Pediatric Diagnosis and Treatment, 8th Edition—Cohen br904
Current Surgical Diagnosis and Treatment, 6th Edition—Spiro br83
Current Therapy in Obstetrics and Gynecology II—Hansen br433

D

D'Agostin, Henry, M.D. ..... †1105
Daniels, Richard A., M.D. *481
Death, Pronouncement of bt589
Deaths Related to Narcotics Overdose in New Jersey—Feuer; French *291
Delisi, A.M., M.D. *849
Demographic Study of Membership bt143
Derman, Arnold, M.D. cr45
Deuell, William D., M.D. ..... †520
DeVivo, John A., M.D. ..... †685
Diabetes: A New and Complete Guide to Healthier Living—Einhorn br344
Diagnostic Virology Laboratory Report—Michalski 425
Dialysis for End-Stage Renal Disease—Walker; Dodelson; Eisinger *1067
Dickinson, George W., M.D. ..... †685
Disorders of the Hip—Goldstone br344
Dodelson, Robert, M.D. *1067
Donnelly, John H., M.D. ..... †34
Dopamine Receptors, Pharmacological Basis of Therapeutics—Heikkila *108
DRG: New Jersey and the Federal System—Rineberg cm40
DRG Position bt50
DRG Waivers bt235, bt89
DRGs: Two Viewpoints—Maressa; Rubacky le68
DRGs: Update of—Johnson cm89
Dropping the Ball: Tennis, Golf, and Alcohol—Van Ost ed18
Drossner, Jacob L., M.D. ..... †60
Dues Discount for Medical School Faculty bt14

E

Effects of AIDS on Various Aspects of Blood Banking—Kuriyan; Muschenheim; Bianco *87
Eicosanoids—Mediators of Biological Functions—Wolff 50
Eisinger, Robert P., M.D. *106
Elective Offices of MSNJ bt32
Electrocardiogram in Infants and Children: A Systemic Approach, The—MacMillan br51
Emergency Medicine—Karel br24
Endoprosthesis for the Management of Incurable Esophageal Carcinoma, Peroral Esophageal—Kalkay; Pancer; Derman cr45
Esposito, Joseph I., M.D. ..... †251
Essertier, H.C., M.D. ..... †346
Ethics, AMA Principles of Medical sa31
Evaluation and Decision Making for Health Services Programs—Madara br519
Evaluation of the Suicidal Adolescent Patient Admitted to an Urban Hospital—Pierog; Hill ... *197
Extra-Anatomic Bypasses in Aortoenteric Fistulas—Antinori; Kain; Kuchler; Manuele; Pierucci; Villanueva cr393
Eye Health Screening Week—Cinotti ed632
Eye Screening Coordinating Council bt893

F

Familial Dysalbuminemic Hyperthyroxinemia: A Variant—Goldman; Klinges cr404
Farmer, Walter D., M.D. ..... †435
Farrer, William E., M.D. cr317
Fayemi, A. Olusegun, M.D. cr43, cr49
Fedder, Marc, M.D. *941
Fee Freeze bt893
Fee Freeze, Medicare bt997
Ferrary, Paul B., M.D. ..... †154
Fertilization in New Jersey: Initial Experience with In Vitro—Kemmann; Colburn; Pasquale; Nosher; Brandeis; Delisi; Shelden *849
Fetal Alcohol Syndrome, Task Force on 146
Feuer, Elizabeth, M.D. *291
Fickeissen, Janet L., R.N. *805
Filippone, Dennis R., M.D. 331
Finance and Budget, Committee on bt510
Fine-Needle Aspiration in Metastatic Malignant Melanoma—Rothman; Olaizola; Baker cr135
Finkel, Jerrold S., M.D. ..... †1005
First Clinical Year of Medical School, The—Kranzler; Vitting; Reynolds *113
Fischer, Alvin L., M.D. ..... †685
Fistulas, Extra-Anatomic Bypasses in Aortoenteric—Antinori; Kain; Kuchler; Manuele; Pierucci; Villanueva cr393
Fitzpatrick, Thomas P. *701
Flashback, Risks Associated with Post-traumatic—Burstein *863
Frank, Perry, M.D. ..... †520
Frantantuno, M.J., M.D. ..... †346
Franz, Ronald L., M.D. ..... †906
French, John, M.A. *291
Frost, Inglis F., M.D. ..... †1105
Fulcrums and Forums, and Clout—Bourns le681

Fundamentals of Family Medicine—Peyser br249
Fundamentals of Immunology, 2nd Edition—Luddecke br519

G

Gambling, New Jersey Initiates Steps To Combat Compulsive—Klein *1051
Gardam, Joseph W., M.D. ..... †685
Gardner, Kenneth E., M.D. ..... †1105
Gáspár, István A., M.D. cr557
Geller, Herbert M., Ph.D. 322
Gellman, Mrs. William B. 475
Geriatric Assessment Programs—Rubenstein *651
Geriatric Imperative *637
Ghiatas, Abraham, M.D. *867
Gilbert, Donald K., M.D. ..... †346
Glasgold, Alvin I., M.D. *187
Glick, Bernard, M.D. ..... †520
Golden Merit Awards 476
Goldman, Michael H., M.D. cr404, cr501
Goldstein, Herman H., M.D. ..... †82
Goldstein, Jonathan, M.D. *110
Good, Charles K., M.D. ..... †686
Gossypol, An Oral Male Contraceptive—Penningroth . 663
Gotsch, Audrey R., Ph.D. *493
Greenfield, Arthur W., M.D. ..... †435
Gregory, Margaret, M.D. *549, *935
Grieco, Emil H., M.D. ..... †906
Gross, Arthur F., M.D. ..... †251
Grossman, Bernard, M.D. op421
Guide to Cardiology, The—Rowen br684
Guided Blind Endotracheal Intubation—Choi; Potian; Yoo; Wu cn569
Guthorn, Peter J., M.D. *769

H

Haft, Jacob, M.D. *110, *211
Hall, Perry O., M.D. ..... †154
Halperin, David, M.D. ..... †251
Handbook of Pediatric Primary Care, 2nd Edition—Vanore br996
Hansen, Gerard F., M.D. *935
Hardwick, Chuck *1046
Harrington, John H., M.D. ..... †520
Harris, Edward, M.D. *661
Haycock, Christine E., M.D. *773
Health and Human Values: A Guide to Making Your Own Decisions—Nevins br1103
Health Care Facilities Planning Act bt894
Health Care Facility Committee, Blue Ribbon Ad Hoc bt143
Heart, Multiple Imaging Procedures—Ketyer br83
Hebble, Judy *493
Heikkila, Richard E., Ph.D. *1084
Hely, Charles J., M.D. ..... †1005
Henderson, George T., M.D. ..... †251
Hermann, John H., M.D. ..... †435
Hill, Austin, Ph.D. *197
Hill, Clarence T., M.D. ..... †607
Hinman, Alan R., M.D. *899
Hirsch, Paul J., M.D. 71, 145, 238, 330, 424, 511, 980
Historiography, 1964-1984, New Jersey Medical—Cowen *807
History of Medicine and Medical Care in New Brunswick, The—Reitman *737
Hitzemann, Luis A., M.D. ..... †686
HMO Advertising bt589
Holmes, Linda, M.P.A. mh389
Horowitz, Susan B., Ph.D. *187
Hospital Association, The History of the New Jersey—Staab *802
Hospital Governing Boards 21, 107, 185, 283, 465, 545, 635, 847, 931, 1045
Hospital Medical Staff Section bt423
Hubschmann, Otakar R., M.D. *870
Hydatid Disease of the Liver—Kessler; Ketyer; Cholankeril; Cenizal cr131
Hymowitz, Norman, Ph.D. *487
Hyperprolactinemia in a Patient with Pseudotumor Cerebri—Goldman; Rabin cr501
Hypertensive Patients: Promoting Compliance in—Supino; Gotsch; Van Harlingen; Hebble *493
Hyperthyroxinemia: A Variant, Familial Dysalbuminemic—Goldman; Klinges cr404

I

Illustrated Computer Tomography: A Practical Guide to CT Interpretations—Horner br433
Illustrated Textbook of Gynaecology—Hansen br904
Imaging: An Approach to the Diagnosis of Cholecystitis—Zeiger *411
Imaging, Indium-111-Oxine-Labeled Leukocyte—Palace; Crystal *959
Immunizations During Pregnancy—Preblud; Bart; Hinman *889
Impaired Physicians Program 65, 140, 507, 667
Indium-111-Oxine-Labeled Leukocyte Imaging—Palace; Crystal *959
Infantile Embryonal Carcinoma in Children—Affuso; Fayemi cr43
Initial Experience with In Vitro Fertilization in New Jersey—Kemmann; Colburn; Pasquale; Nosher; Brandeis; Delisi; Shelden *849
Insulin-Like Growth Factors, Pharmacological Basis of Therapeutics—Brostrom *967
Interface between the Acute Hospital and Long-Term Care, The—Kane; Kennie *643
Intrauterine Testicular Torsion—Rosenberg; Zimmerman cr320
Intubation, Guided Blind Endotracheal—Choi; Potian; Yoo; Wu cn569
Is There a Doctor in the House?—Primich ed1041
Is There an Indigenous Viral Flora in Man?—Michalski *121

J

Jacobus, Raymond E., M.D. ..... †520
James, Harold E., M.D. ..... †154
JEMPAC Report 26
JEMPAC Update—Ryan *586
Jewel, Kenneth L., M.D. *297, *884
Joel, Lucille A., Ed.D. *655
Johnson, Edward S., M.D. *941
Johnson, Martin E. cm891
Journal Format, *The*—Bergen; Sakson le517
Journalism, The History of Medical, in New Jersey—Krosnick *723
Juhasz, Nicholas M., M.D. ..... †686

K

Kain, E.H., M.D. cr393
Kalkay, M. Nuri, M.D. cr45
Kane, William J., M.D. *643
Karl, Sarah *487
Karshmer, Nathan, M.D. ..... †251
Katcher, Avrum L., M.D. ed106
Keates, George H., M.D. ..... †907
Kemmann, E., M.D. *849
Kennie, David C., M.D. *643
Kessler, Michael A., M.D. cr131
Ketyer, Sidney, M.D. cr131
Kilmer, Frederick B., A Notable New Jersey Pharmacist—Bowers *765
Klein, Robert M. *1051
Kler, Joseph H., M.D. ..... 75, †251
Kline, Oram R., M.D. ..... †346
Klinges, Karl, M.D. cr404
Kohn, Herbert, Ph.D. *311
Koralek, Adolph, H., M.D. ..... †346
Kostant, George H., M.D. ..... †251
Kostis, John, M.D. *949, *1055

Kovacs, Alexander, D., M.D. 70, 144, 473
Kranzler, Henry, M.D. *113
Kratka, Harold D., M.D. ..... †1006
Krieger, Abbott J., M.D. *870
Krosnick, Arthur, M.D. mh138, *723
Kubes, Zdenek, M.D. ..... †435
Kuchler, J.A., M.D. cr393
Kudos to *The Journal*, Its Staff, and Others ed462
Kuriyan, Mercy, M.D. *875
Kustrup, Dr. John F., M.D., 1907-1984 ..... ed842

L

Ladas, George, M.D. ..... †251
Landay, Merwyn A., D.D.S. *37
Laquatra, Idamarie *487
LaPorta, Michael L., M.D. ..... †686
Lasker, Norman, M.D. *415
Laufenberg, Joseph W., M.D. ..... †907
Law of Medical Practice in Pennsylvania and New Jersey, The—George br905
Law of the Duck, The—Minzter le343
Leach, John E., M.D. ..... †607
Legal Services Plan bt509
Legislation, Current 1089
Lenape Contribution to New Jersey Medicine, The—Fitzpatrick *701
Length of Stay—Dang le995
Letters to the Editor 81, 153, 247, 342, 517, 604, 681, 903, 995
Limited Licensed Practitioners bt589
Liver, Hydatid Disease of the—Kessler; Ketyer; Cholankeril; Cenizal cr131
Loigman, Barry I., M.D. *884

M

Macaulay, Francis A., M.D. ..... †1006
Maciorowski, Linda, R.N. *549
Magnetic Resonance Imaging (MRI)—Jewel, Loigman; Mattern; Richman; Royer; Whelan *884
Male Reproduction and Fertility—Leyson br250
Mancene, Edward M., M.D. ..... †607
Mandatory Assignment bt589; le604
Manual of Clinical Gastroenterology—Riegel br83
Manuele, V.J., M.D. cr393
Maressa, Vincent A., M.D. cm409
Marrella, Louis F., M.D. ..... †82
Martland, Harrison F., M.D.—Bellet; Berg le342; le903
Martucci, Mary, R.N. cn573
Mass for Physicians—Desmond le681
Maternal Deaths in New Jersey, 1982—Hansen; Gregory *935
Mattern, Richard R., M.D. *884
May A Blood Bank Refuse Donations To Prevent the Spread of AIDS?—Smith; Brennan; McDonough *125
McCormack, John L., M.D. *190
McCue, John B., M.D. ..... †252
McDonough, Brian, J.D. *125
McDonough, Robert B., R.N. *549
Medicaid Cost Containment bt893
Medical Care, The Rising Cost of ed841
Medical Dynasty in New Jersey, A—Brodman *779
Medical Philately—Kler 75
Medical Staff Standards bt235
Medication Dispensing bt423
Medicine for the Practicing Physician—Poppick br250
Medicine in New Jersey to 1825, A Sketch of—Saffron *709
Meehan, Martin M., M.D. ..... †82
Melanoma, Fine-Needle Aspiration in Metastatic Malignant—Rothman; Olaizola; Baker cr135
Meltsner, Louis, M.D. ..... †252
Membership Newsletter 7, 94, 167, 265, 359, 449, 532, 619, 829, 919, 1021
Merritt's Textbook of Neurology, Seventh Edition—Leonberg br1104
Method of Abdominal Wound Closure, A—Samson; Schulman; Sabo; Schulman; Silvers *205
Mettler, Fred A., M.D. ..... †1105
Metzer, Freeman W., M.D. ..... †435
Michalski, Frank J., Ph.D. *121, 425
Microsurgical Resection of AV Malformations from Vital Areas of the Brain—Hubschmann; Krieger *870
Midtrimester Amniocentesis for Prenatal Diagnosis—Ghiatas *867
Milch, Ronald B. *647
Miller, Eva, M.S. *549
Miller, Michael H., Ph.D. *311
Mintz, Gary, M.D. *481
Mitral Valve Replacement, Aortic and—Olivieri; Kostis *949, *1055
Modarelli, Walter H., M.D. ..... †1006
Moeckel, C. William, M.D. ..... †1105
Morlino, John, D.O. cn573
MSNJ: America's First and Oldest Medical Society—Hutner *718
MSNJ Annual Meeting ed543
MSNJ Auxiliary 71, 145, 237, 329, 673, 895, 979, 1089
MSNJ News—Via HIN TV ed180
Muschenheim, Frederick, M.D. *875
Myers, Norman V., M.D. ..... †686
Myth or Fact: Can Women Self-Diagnose Pregnancy?—Bachmann *857

N

Narcotics Overdose in New Jersey, Deaths Related to—Feuer; French *291
Nelson's Textbook of Pediatrics, 12th Edition—Katcher br684
Nevins, Michael A., M.D. cm222, *637, *661
New Frontiers in Mammary Pathology—Rathmell . br519
New Jersey Initiates Steps To Combat Compulsive Gambling—Klein *1051
New Jersey Hospital Association bt68
New Members 71, 330, 511, 673, 895, 1093
Newell, William Augustus, M.D., and the Life Saving Service—Guthorn *769
Ney, Dolores, R.N. cn573
Nobile, James J., M.D. ..... †435
Nominating Committee, Report of 335
Nosher, J., M.D. *849
Nuclear Magnetic Resonance (NMR) Imaging—Horner br434
Nurses' Association, New Jersey State—Fickeissen *805

O

Ober, William B., M.D. *878
Obituaries 82, 154, 251, 346, 435, 520, 607, 685, 906, 1005, 1105
Olaizola, Yayone, M.D. cr135
Olivieri, Philip, M.D. *949, *1055
Olson, Vendela E., M.D. ..... †520
Opportunity for Change, An—Milch *647
Orthopaedic Society, New Jersey bt997
Osteopathic Medicine in New Jersey, The First 40 Years—Thompson; Chico *798
Out-of-Hospital Births: A Survey of Patients—Gregory; McDonough; Maciorowski; Miller *549
Ovarian Tumors in Postmenopausal Women, Androgen-Secreting—Ober *878
Overcoming Psychic Numbing—Grossman op421
Ownership Statement 988

P

Pacemaker Therapy—Rothfeld br434
Palace, Fred M., M.D. *959
Pancer, Bernard, M.D. cr45
Pancreatic Pseudocyst Associated with Valproic Acid Therapy—Baskies cr399

Parvin, Robert W., M.D. ..... †1006
Pasquale, S., M.D. *849
Patient Care at State Psychiatric Institutions and Mental Health Centers bt235
Patient Education Program bt589, bt893
Pediatric Briefs 63, 325, 973
Peer Review Organization bt143
Pelosi, Marco A., M.D. *303
Pennington, Stephen M., Ph.D. 663
Peroral Esophageal Endoprosthesis for the Management of Incurable Esophageal Carcinoma—Kalkay; Pancer; Derman cr45
Petrosino, Carmen P., M.D. ..... †907
Pharmacological Basis of Therapeutics 322, 503, 663, 967, 1084
Phimosis: A Cause of Renal Failure—Rosenberg le81
Physical Examinations by Nurses bt423
Physical Therapy and Unlicensed Aides bt509
Physician Legal Bulletin 285, 623, 1033
Physicians in the Mouse Trap—Smith ed371
Physicians Seeking Location in New Jersey 72, 146, 238, 332, 426, 512, 594, 674, 896, 980, 1094
Pierog, Sophie, M.D. *197
Pierucci, L., Jr., M.D. cr393
Pneumonitis, Acute Radiation—Silberstein, Malcolm; Braun; Fayemi cr49
Pollack, Irwin W., M.D., Piscataway *311
Pollis, Nicholas L., M.D. ..... †1006
Pores, Ira H., M.D. ..... †907
Postmyocardial Infarction Rupture of the Ventricular Septum—Agarwal; Haft; Goldstein *110
Potian, Marcelino, M.D., Newark cn569
Power and the Profession of Obstetrics—Abrams ... br344
Practical Infectious Diseases—Mauriello br250
Practical Solutions to Common Transfusion Problems—Taylor 591
Preblud, Stephen R., M.D. *889
Pregnancy, Immunizations During—Preblud; Bart; Hinman *889
Pregnancy, Myth or Fact: Can Women Self-Diagnose?—Bachmann *857
Pregnancy, Termination of bt1088
Premenstrual Syndrome: Fact or Fantasy? Pelosi *303
Prescriptions for Controlled Substances bt235
President's Column—Kovacs 69, 144, 236, 328
Presidential Column—Minzter le343
Preventing Death from "Hits"—Sugerman ed281
Primary Prevention of Coronary Heart Disease: A Practical Guide for the Clinician—Poppick br155
Primich, Frank J., M.D. ed1041
PRO bt423, bt510
Professional Liability Commentary 13, 99, 175, 276, 365, 456, 537, 629, 837, 923, 1037
Progress in Cardiology, Volume II—Poppick br518
Promoting Compliance in Hypertensive Patients—Supino; Gotsch; Van Harlingen; Hebble *493
Pseudocyst Associated with Valproic Acid Therapy, Pancreatic—Baskies cr399
Pseudotumor Cerebri, Hyperprolactinemia in a Patient with—Goldman; Rabin cr501
Psychological Effects of Rhinoplasty—Glasgold; Horowitz *187
Psychological Impact of Cancer on Patient and Family, The—Singer *383
Pulmonary Edema Complicating Epiglottitis—Blankson; Scott; Bekes le247

Q

Quality of Care Audit of Services bt589

R

Rabin, Aaron, M.D. cr501
Radiographic Findings in Pseudomembranous Colitis—Altin cr217
Radionuclide Testicular Scanning—McCormack *190
Ramamurti, Suresh, M.D. cr317
Rangwala, Anis F., M.D. *481
Read, Hilton S., M.D. ..... †346
Reading, Edward G., M. Div. ip667
Rehabilitation of Cognitive Function in Brain-Damaged Persons—Pollack; Kohn; Miller *311
Reich, Samuel B., M.D. ..... †521
Reitman, Norman, M.D. *737
Renal Disease, Dialysis for End-Stage—Walker; Dodelson; Eisinger *1067
Renal Failure, Diet and Nutrition in Chronic—Lasker *415
Reorganization of Hospital Staff—Harris le342
Retired Lines Reserve 1092
Review of Microbiology—Smith br905
Reynolds, Richard C., M.D. *37, *113
Rhinoplasty, Psychological Effects of—Glasgold; Horowitz *187
Richman, Steven D., M.D. *884
Rineberg, Bernard A., M.D. cm406
Risks Associated With Post-traumatic Flashbacks—Burstein *863
Rocco, Leo C., M.D. ..... †607
Rosamilia, Ralph E., M.D. ..... †1105
Rosen, Charles D., M.D. ..... †907
Rosenberg, Joel, M.D. *320
Rossi, John R., M.D. ..... †907
Rothberg, Harvey, M.D. cm229
Rothman, Donald, M.D. cr135
Royer, Charles C., M.D. *884
Rubenstein, Laurence Z., M.D. *651
Rusin, Michael J., M.D. ..... †252
Ryan, William E., M.D. *586

S

Sabo, Jack C., M.D. *205
Saffron, Morris H., M.D. *709, *785
Samson, Ian D., M.D. *205
Sandella, Joseph F., M.D. ..... †1006
Saul, Maslah, M.D. ..... †607
Sawyer, Blackwell, M.D. ..... †907
Schefrin, Alexander E., M.D. ..... †82
Schiffman, Raymond, M.D. cr563
Schulman, Jesse, M.D. *205
Schulman, William M., M.D. *205
School, The First Clinical Year of Medical—Kranzler; Vitting; Reynolds *113
Sciortino, Joseph, M.D. ..... †907
SCRAP—Hymowitz; Laquatra; Karl *487
Selection of a Blue Cross/Blue Shield Trustee—Maressa ed463
Selection of a Medical Office Computer System—Allen *377
Seltzer, Murray H., M.D. le153
Septum, Postmyocardial Infarction Rupture of the Ventricular—Agarwal; Haft; Goldstein *110
Sharpe, William D., M.D. mh53
Shelden, R.M. *849
Should Community Hospitals Have Geriatric Units?—Nevins *687
Silberstein, Stuart, M.D. cr49
Silverman, Theodore M. ..... †1105
Silvers, Lawrence W., M.D. *205
Sims, Eugene W.R., M.D. ..... †82
Singer, Barton A., Ph.D. *383
Smith, Leon G., M.D. *125, ed371, *941
Smoking Cessation Reduction Act Program, The—Hymowitz; Laquatra; Karl *487
Snape, William J., M.D. *731
Social Transformation of American Medicine—Madara br83
Solomon, Robert, M.D. cn573
Source Book of Plastic Surgery, The —Meijer br1104
Specialty Society Representation bt327
Spivak, David, M.D. ..... †907
Spleen, Tuberculous Abscess of the—Farrer; Ramamurti cr317

Sports, Committee on Medical Aspects of bt327
Sports Medicine: Health Care for Young Athletes—Haycock br518
Staab, Linda *802
State Board of Medical Examiners bt68
Stein, Arthur H., M.D. ..... †252
Stein, Steven F., M.D. ..... †346
Stenosis, Cardiac Amyloidosis and Idiopathic Hypertrophic Subaortic—Daniels; Weinberg; Rangwala; Mintz *481
Stewart, Irving J., M.D. ..... †521
Stutchin, Abe D., M.D. ..... †435
Subordinated Loan Certificates bt1088
Sugerman, A. Arthur, M.D. ed281
Suicidal Adolescent Patient Admitted to an Urban Hospital, Evaluation of the—Pierog; Hill *197
Summary Statement of ACP Study Group—Nevins; Alexander; Chinard; Harris; Wallen *661
Supino, Phyllis, Ed.D. *493

T

Tamisiea, John A., Award 896
Taylor, H.L., M.D. 591
Technological Basis of Radiation Therapy: Practical Clinical Applications—Ketyer br684
TEFRA Regulations bt144, bt589
Temporary Vocal Cord Paralysis—Demos le247
Testicular Scanning, Radionuclide—McCormack *190
Testicular Torsion, Intrauterine—Rosenberg; Zimmerman cr320
Third International Symposium of Plastic and Reconstructive Surgery of the Eye and Adnexa—Mauriello br1104
Thompson, Robert L., Ed.D. *798
Tomography-Guided Percutaneous Needle Biopsy, Computerized—Jewel *297
Total Mastectomy *v* Partial Mastectomy and Radiation Therapy—Cabrera; Schwartz le247
Tracheoesophageal Fistula and Arteriosclerotic Aortic Aneurysm—Schiffman cr563
Transfusion Problems, Practical Solutions to—Taylor 591
Trustees' Minutes 68, 143, 235, 327, 425, 509, 589, 893, 977, 1088
Tuberculous Abscess of the Spleen—Farrer; Ramamurti cr317

U

UMDNJ, Medical Education of New Jersey: The Development of—Bergen *785
UMDNJ Notes 70, 144, 237, 329, 424, 510, 590, 762, 894, 979, 1088
Urgi-Centers bt235

V

Vaccine, Adverse Drug Reaction After Administration of Influenza—Solomon; Morlino; Martucci; Ney cn57
Van Harlingen, David, Ed.D. *49
Van Ost, William C., M.D. ed18
Vanderbeek, Stuart W., M.D. ..... †52
Varhol, Joseph G., M.D. ..... †8
Varicose Veins, Related Diseases and Schlerotherapy: A Guide for Practitioners—Alpert br60
Villanueva, D.T., M.D. cr39
Vitting, Kevin, M.D. *11
Vocal Cord Paralysis—Pizzo le8
Voss, John C., M.D. ..... †68

W

Walker, John A., M.D. *106
Wallen, Marven, M.D. *66
Walters, George M., M.D. ..... †25
Watson, Frank Y., M.D. ed461, 46
Weems, Don B., Sr., M.D. ..... †8
Weinberg, Ronald, M.D. *48
Weintraub, William L., M.D. ..... †8
Weisse, Allen B., M.D. mh57
Whatever Happened to Benign Neglect?—Nevins cm22
Whelan, Charles A., M.D. *884
White, Thomas J., M.D. ..... †686
Williams, David P., Jr., M.D. ..... †907
Williams Issue, Comments on—Kohn le681
Williams, William Carlos, A Postscript ed17
Willoughby, Frances L., M.D. ..... †684
Winsten, Sol S., M.D. ..... †154
Winter, Egon W., M.D. ..... †1105
Wolfe, Donald J., Ph.D. 503
Wolfe, Edward L., Ph.D. *731
Women Physicians of New Jersey: The Early Era—Haycock *773
Wound Closure, A Method of Abdominal—Samson; Schulman; Sabo; Schulman; Silvers *205
Wu, Wen-Hsien, M.D. cn569

Y

Yellow Fever During the 18th Century, Preliminary Report of—Snape; Wolfe *731
Yoo, Eun Ye, M.D. cn569
Youngest Science, The—Madara br155

Z

Zeiger, Louis S., M.D. 411
Zimmerman, Milton, M.D. cr320

It's Your Affair, So Don't Lift A Finger

Since we want your special day to be carefree just lift the phone and call

Parties Unlimited

Perfect Catering For A Perfect Affair

Trenton, New Jersey
609-890-0778

MEDICAL COMPUTERS

DEC - IBM - TELEVIDEO ALTOS - NCR

THINKING OF COMPUTERIZING YOUR PRACTICE?

FBL MEDICAL COMPUTER SPECIALISTS offers a wide variety of hardware/software configurations for every medical office, hospital and clinic application.

- AUTOMATIC INSURANCE FORM PREPARATION
- ACCOUNTS RECEIVABLE CONTROL
- AUTOMATIC PATIENT RECALL
- PRACTICE MANAGEMENT REPORTS
- CLINICAL RECORDS
- ACCOUNTS PAYABLE
- APPOINTMENT SCHEDULING
- ELECTRONIC CLAIMS SUBMISSION
- WORD PROCESSING
- MEDICARE/MEDICAID BILLING
- GENERAL LEDGER
- INVENTORY

UNIX SOFTWARE AVAILABLE FOR ALTOS AND NCR
MUMPS SOFTWARE AVAILABLE FOR DEC

SPECIALISTS IN MULTI-USER, MULTI-TASKING DATA-BASE MANAGEMENT SYSTEMS.

FBL

PROVIDING YOU WITH OVER 15 YEARS OF MEDICAL COMPUTER EXPERIENCE

CONSULTING SERVICE AVAILABLE

3 ROUTE 46W, FAIRFIELD, N.J. 07006 201-882-9210

Doctors: Write your own prescription to cure insurance pains . . .

℞ Prescription

Name MSNJ Member

MSNJ Group Blue Cross/Blue Shield Major Medical and Dental Insurance

that provides:

- **Flexible plans**
- **Comprehensive benefits**
- **Low, competitive rates**
- **Centralized Administration**

Designed and Administered by
DONALD F. SMITH & ASSOCIATES

℞ Prescription

Name _____

Address _____

Phone _____

Please send more information on the MSNJ

☐ Blue Cross/Blue Shield Program
☐ Major Medical Program
☐ Group Dental Program

Return to:
Donald F. Smith & Associates
One Airport Place, Route 206 North
P.O. Box 2197,
Princeton, New Jersey 08540
(609) 924-8700, (201) 622-6046

AUTHOR INFORMATION

Style Sheet

The Journal is the official organ of the Medical Society of New Jersey. The goals of The Journal are educational and informational. All material published in The Journal is copyrighted by MSNJ.

CONTENT

The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports based on unusual clinical experiences; review articles; clinical notes, succinct items on some aspect or new observation or technique of a case experience; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update; and an opinion column. Editorials are prepared by the Editor and by guest contributors on timely and relevant subjects; editorials are the responsibility of the author. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the Editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made in New Jersey.

ASSIGNMENT OF COPYRIGHT

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978), a transmittal letter or a separate statment accompanying material offered to *The Journal* of the Medical Society of New Jersey must contain the following language and must be signed by all authors:

"In consideration of *The Journal* of the Medical Society of New Jersey taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *The Journal*, MSNJ."

SPECIFICATIONS

Submit two **manuscripts** that must be typewritten and double-spaced on 8½" by 11" paper. Statistical methods used in articles should be identified. Acknowledgements will be made only for specific preparation of an essential part of the manuscript.

Authors are asked to seek clarity, accuracy, and originality; attention to details of grammar, spelling, and typing are important.

The **title page** should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

The author should submit a 40-word **abstract** to be used at the beginning of the article.

Tables must be typewritten and double-spaced on separate 8½" by 11" sheets, with a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source; written permission for republication from the original publisher must be submitted. The cost of color photographs must be borne by the author.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

The **summary** of the article should not exceed 250 words; it should contain only essential facts.

References should not exceed 35 citations except in review articles, and should be cited consecutively in the text by numbers in parentheses at the end of the sentence. The reference list should be typewritten and double-spaced on separate 8½" by 11" sheets in the numerical order in which they are first cited in the text. The style of reference is that of *Index Medicus:*

1. Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis.* New York, NY, McGraw-Hill, 1969, pp 42-48.

PUBLICATION POLICY

Receipt of each manuscript will be acknowledged and a copy delivered to the Editor who refers the paper to one or more members of the Editorial Board. The final decision is reserved for the Editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. Galley proofs will be submitted to the author for correction of typographical errors.

REPRINT ORDERS

Reprints may be ordered after the author is notified that the article has been selected for a specific issue of JMSNJ. A check for the cost of reprints including remake charge if order is received after due date must accompany the order.

COMMUNICATIONS

All communications should be sent to the Editor, *The Journal*, MSNJ, 2 Princess Road, Lawrenceville, NJ 08648.

ıericana
st Farm Resort

HOUSING APPLICATION

219TH ANNUAL MEETING
MEDICAL SOCIETY OF NEW JERSEY
THURSDAY, MAY 2, TO SUNDAY, MAY 5, 1985

FOLLOWING ARE ALL-INCLUSIVE PACKAGE PLANS BASED ON IFIED AMERICAN PLAN, INCLUDING DINNER AND BREAKFAST Y STARTING WITH DINNER ON THE DAY OF ARRIVAL, THE SAT-AY NIGHT BANQUET, LIVE CABARET SHOWS EACH EVENING 'URING A DIFFERENT SHOW EVERY NIGHT, STATE SALES TAX, ALL GRATUITIES COVERING BELLMEN FOR IN/OUT LUGGAGE /ICE, CHAMBERMAIDS, AND ALL MEAL SERVICE AS OUTLINED:

R-NIGHT PACKAGE
.00 PER PERSON, SINGLE OCCUPANCY
.00 PER PERSON, DOUBLE OCCUPANCY
.00 PER CHILD SHARING A ROOM WITH PARENTS

EE-NIGHT PACKAGE
.00 PER PERSON, SINGLE OCCUPANCY
.00 PER PERSON, DOUBLE OCCUPANCY
.00 PER CHILD SHARING A ROOM WITH PARENTS

-NIGHT PACKAGE
.00 PER PERSON, SINGLE OCCUPANCY
.00 PER PERSON, DOUBLE OCCUPANCY
.00 PER CHILD SHARING A ROOM WITH PARENTS

- **Forms received after April 1, 1985, will be confirmed on an "if available" basis.**
- **Fill out only one form for each room required.**
- **DEPOSIT OF $100 PER ROOM MUST ACCOMPANY FORM TO CONFIRM RESERVATIONS.**
- **Please make check payable to HOST FARM. Major credit cards accepted at hotel, but not for deposit.**
- **Hotel confirmation is required for check-in.**
- **Send form and deposit to:**
  Host Reservations
  2300 Lincoln Highway East
  Lancaster, PA 17602
  717-299-5500

CK TYPE OF ROOM REQUIRED: ☐ **SINGLE OCCUPANCY** ☐ **DOUBLE OCCUPANCY**
☐ **WILL BE SHARING ROOM****

e hotel will not be responsible for assigning roommates. Unless roommate is stated, you will be assigned a single occupancy accommodation.

SE PRINT OR TYPE THE FOLLOWING INFORMATION:

E: _____ NO. of CHILDREN: _____

MMATES: _____ CHILDREN'S AGES: _____

_____

_____

RESS: _____

_____

NE: _____ STATE: _____ ZIP: _____

CK IF OFFICIAL DELEGATE ☐ COUNTY: _____

VAL DATE _____ DAY _____

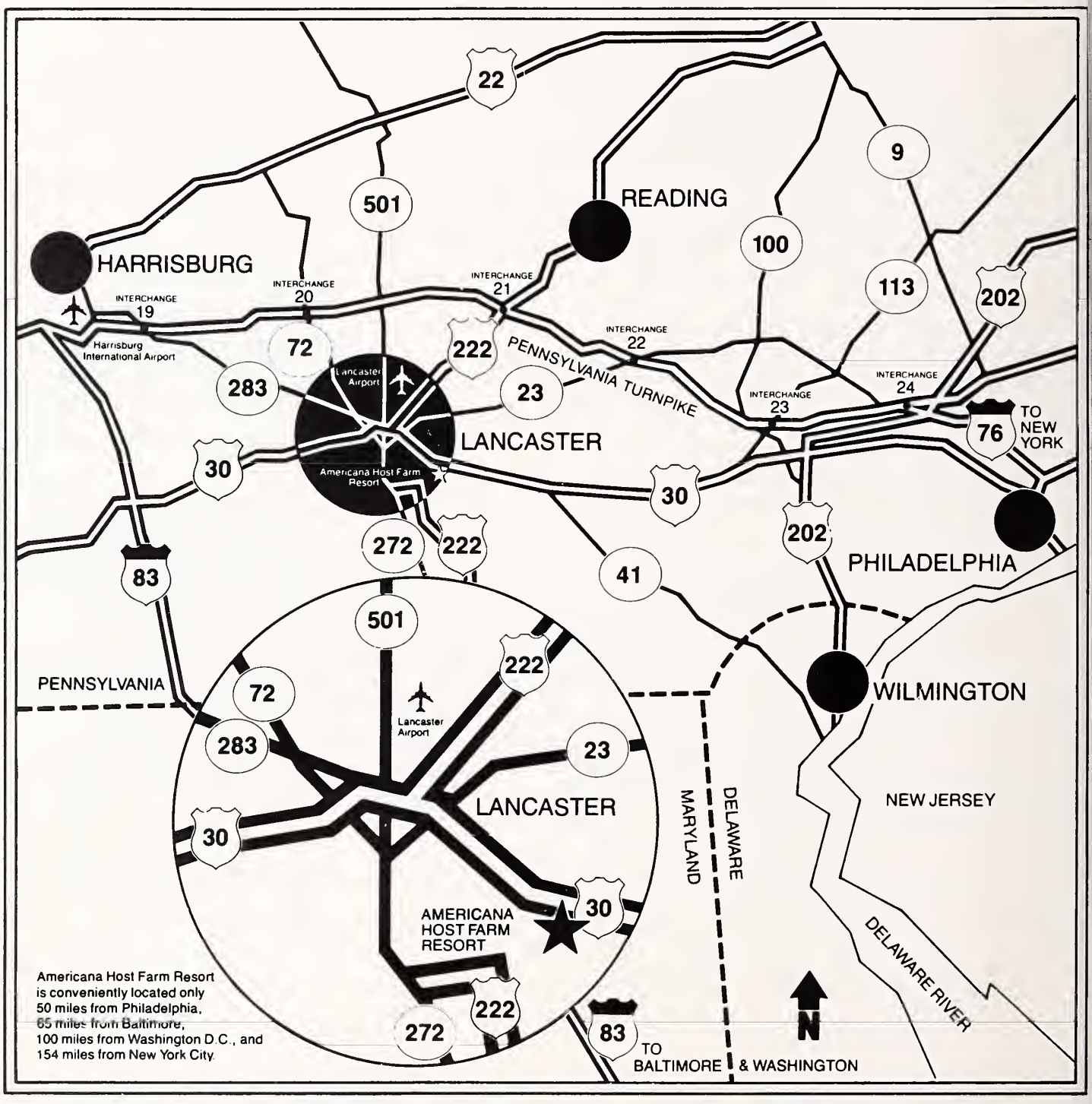
RTURE DATE _____ DAY _____

CHECK-IN: AFTER 4 PM
CHECK-OUT: BY 12 NOON

MEDICAL SOCIETY OF NEW JERSEY—219TH ANNUAL MEETING #2220

Americana
Host Farm Resort

2300 Lincoln Highway East (Route 30), Lancaster, Pennsylvania 17602 (717) 299-5500



FROM NEW YORK
Take New Jersey Turnpike South to Pa. Turnpike. Take Pa Turnpike West to Interchange No. 21. Travel South on U.S. Rte. 222 to U.S. Route 30. Travel East on U.S. Route 30, approximately 5 miles to Americana Host Farm Resort.

FROM PITTSBURGH & POINTS WEST
Travel East on Pa. Turnpike to Int. 19. Go South on I-283 for 30 miles into Route 30 East for 6 miles to Americana Host Farm Resort.

FROM PHILADELPHIA
Take Pa. Turnpike West to Interchange No. 21. Travel South on U.S. Rte. 222 to U.S. Route 30. Travel East on U.S. Route 30, approximately 5 miles to Americana Host Farm Resort.

FROM BALTIMORE & WASHINGTON
Go North on Interstate Route 83 to York, Pa. Turn East on U.S. Route 30 for 32 miles to Americana Host Farm Resort.

BY AIR
Harrisburg International Airport (just 35 minutes from Host by limousine or car) via TWA and U.S. Air, and Lancaster Airport only minutes away with daily flights via U.S. Air.

BY RAILROAD
Amtrak to Lancaster Station. Taxi and Rent-a-Car Service available.

MEDICAL RESIDENT IN INTERNAL MEDICINE wanted for diagnosis and treatment in all areas of internal medicine under supervision of hospital staff. Requires M.D. degree in Medicine and one year training as a Medical Resident; $22,785 per year; 40 hours a week. Send resumes to Hackensack Job Service, 50 Passaic Street, Hackensack, New Jersey 07601. J.O. #0964012 No fee charged.

CARDIOLOGIST:

Opportunity to practice cardiology with well-established practice conveniently located to a large teaching hospital. Duties include supervising and interpreting Treadmills, Holter monitors, 2D and M-Mode Echocardiography performed in office, patient examinations, hospital rounds and cardiac catheterizations. Abilities to do streptokinase and/or angioplasty desirable. Excellent beginning salary and fringe benefits. Located in Pennsylvania.

Reply with C-V to Box No. 97, JMSNJ Immediate Opening.

ORTHOPEDIC SURGEON

Excellent opportunity for board eligible/certified Orthopedic Surgeon to replace same in medium-sized city in progressive/rural Eastern Pennsylvania. Candidate should have significant interest in sports medicine. Call Judith Kennedy at 1-800-441-0996 or in PA at 215-896-5080 collect.

PRACTICE OPPORTUNITIES

ALLERGY—Suburban Philadelphia—fully equipped, excellent staff, and favorable lease.

PEDIATRICS—New Jersey near NYC—very successful practice with excellent growth record.

ENT—Pennsylvania—large, fast-growing practice. All new equipment.

M/RHEUMATOLOGY—Arizona—well-equipped practice in large city.

OB/GYN—Washington State—Seller moving, needs Buyer ASAP.

ALLERGY/IMMUNOLOGY—Close to New York City. Good opportunity for Pediatrician/ Allergist.

or more information on these or other practice ales or position opportunities, call (215) 67-8630 or send your Curriculum Vitae to:

HEALTH CARE
PERSONNEL CONSULTING
403 GSB Building
Bala Cynwyd, PA 19004

OBSTETRICIAN/GYNECOLOGIST

Attractive opportunity for board eligible/certified OB/GYN to establish practice in medium-sized city in progressive/rural Eastern Pennsylvania. Candidate must be supportive of hospital midwifery program. Call Judith Kennedy at 1-800-441-0996 or in PA at 215-896-5080 collect.

SPECIALISTS!

If you're a pediatrician, OB/GYN or other medical specialist, we need your services to complete a brand-new, elegant, boutique-style shopping and office center. Excellent location in upscale, affluent, growing area. Just 5 miles from Middlesex General University Hospital and St. Peters Medical Center. Several medical offices within center. Hidden Lake Towne Center. Between Routes 1 and 27 in North Brunswick, New Jersey.

For information, please call (201) 846-5700.

MEDICAL PRACTICE SALES AND APPRAISALS

We specialize in the valuation and selling of medical practices. If interested in buying or selling a medical practice, contact our Brokerage Division at:

Health Care Personnel Consulting, Inc.
403 GSB Building
1 Belmont Avenue
Bala Cynwyd, PA 19004
215-667-8630



RESIDENTIAL/PROFESSIONAL

Luxury Ranch in Hartshorn location. 3 bedrooms, 3 baths. 50 foot expanse for living and dining rooms. Den with fireplace plus 5 room professional suite. $469,000. Call 201-467-3883. Evenings call Phyllis Brightman at 201-376-5342.

DEGNAN & BOYLE REALTORS
The Sign of Experience

MILLBURN/ SHORT HILLS
59 Main Street
201-467-3883

OPHTHALMIC SURGI-CENTER AND LARGE EYE CLINIC AVAILABLE AT ONCE.

Capacity for over 400 major and 900 minor surgical procedures. Eye clinic capacity, 12,000 per year. Deluxe living quarters.

CALL 215-423-4477.
N.A. KARAKASHIAN, M.D.

UNIQUE BUSINESS OPPORTUNITY FOR PHYSICIANS

American Bloodpressure Centers, Inc. is a rapidly growing chain of hypertension treatment facilities located in major regional shopping malls. If you would like to explore how this sound business growth opportunity might help you build toward a financially secure future contact:

Richard E. Winter, M.D.
Chairman of the Board
777 Third Avenue
New York, New York 10017
212-303-1706

Don't take a chance with your career...



Emergency Physician Associates is seeking physicians with Emergency Medicine, Internal Medicine and Family Practice backgrounds who are experienced and interested in a challenging career in Emergency Medicine.

We are currently interviewing for positions in N.J., Pa., N.Y., De. and Md.

Send your C.V. in confidence to:
James E. George, M.D.
Emergency Physician Associates
P.O. Box 298
Woodbury, N.J. 08096
Or call Donna L. Wallace, Physician Recruitment at (609) 848-3817.

Need A Temporary Physician?

You can take time off while your practice keeps working! Lease CompHealth physicians for your vacations, CME's or for supplementary help.

Want Free Time While You Practice Medicine?

Join CompHealth's Locum Tenens Physician Group.

★

For further information about temporary coverage or locum tenens practice opportunities, call:

412-741-3310

CompHealth
A Physician Group

WILSON ROSS, Regional Administrator
114 Centennial Avenue
Sewickley, PA 15143

CLASSIFIED ADVERTISEMENTS

CARDIOLOGIST/INTERNIST NEEDED—Cardiologist needed for multi-specialty internal Medicine group in the South Jersey area near Atlantic City. Salary with eventual partnership. Excellent benefit package. If interested please send curriculum vitae to Box No. 102, JMSNJ.

EMERGENCY PHYSICIAN NEEDED—For new urgent care center in West Morris County. Excellent opportunity. Reply Box No. 104, JMSNJ.

FAMILY PHYSICIAN/INTERNIST NEEDED—BC/BE opportunity for personable, energetic physician in expanding practice, Central New Jersey. Immediate opening or July, 1985. Send CV to Box No. 111, JMSNJ.

NEEDED: GENERAL INTERNIST—Ideal Central New Jersey practice. Position available immediately. Reply Box No. 112 JMSNJ.

INTERNIST NEEDED—To join active three-man pediatric practice. Fully furnished offices with lab and x-ray available. Excellent opportunity. 201-584-9390.

PHYSICIANS NEEDED—For successful well known walk-in medical office center, Central NJ. Full and part-time. Skilled and personable American trained MDs send CV to E.V. McGinley, M.D., 1005 N. Washington Avenue, Green Brook, NJ 08812.

PHYSICIANS NEEDED—New professional office center. Ideal location for all specialties. X-ray and lab available. Many extras. 201-584-9390.

PHYSICIAN NEEDED—Full and part-time physicians/general practice needed for new medical center in Little Falls, NJ. Call Sandy at 201-890-0855 for further information.

DIAGNOSTIC RADIOLOGIST—32 year old Mayo Clinic trained Diagnostic Radiologist experienced in all aspects of Radiology seeks opportunity to practice in New Jersey or greater Philadelphia area. Interested in locum tenens, interpreting all/or selected films, full or part-time position in a clinic setting. Call 215-245-8904.

FAMILY PRACTICE—Board eligible, ACLS certified, personable, American graduate. Desires office/hospital work in Central/Northern New Jersey. Please call, if interested, 201-245-7162 or write to 218 Chestnut St., #A-6, Roselle Park, NJ 07204.

ORTHOPAEDIC SURGEON—American graduate, trained at Downstate Medical Center, NJ. Seeks solo, group or hospital based position. Call 212-819-8706 during business hours or write to Box No. 100, JMSNJ.

RADIOLOGIST—Board certified in radiology and nuclear medicine. NJ licensed. Teaching hospital affiliation, desires supervision of Nuclear Medicine with ultrasound and CT. Reply Box No. 107, JMSNJ.

RADIOLOGIST—Recently retired, BC, very experienced, would like part-time work; Central NJ, have car, will travel. Write Box No. 110, JMSNJ.

RADIOLOGIST—Five years teaching hospital base experience in Diagnostic Radiology. Seeking to buy a well established practice, Solo or Partnership. Write to M.M. Bashiri, M.D., 104-20 Queens Blvd, Forest Hills, NY 11375.

FOR SALE—HOME/OFFICE—Four bedroom colonial with 800 square foot office attached with 4 exam rooms, lab and waiting room. Located in fastest growing area in NJ—Marlboro, Manalapan Township. Asking $154,500. Call 201-946-2286.

FOR SALE—Established Primary Care Practice in Ocean County area. X-ray equipment, EKG and cardiac monitor. Write Box No. 103, JMSNJ.

FOR SALE—Vectra camera for mammary thermography. Used two years, like new. Call 201-992-0450. Leave return number on tape.

OFFICE SPACE—Kenilworth, NJ. Space available for rent in medical office. Write Box No. 109, JMSNJ.

OFFICE SPACE RENT or SHARE—New Brunswick/Highland Park area. Furnished 700 square feet. Ample parking, close to the hospital. For Rent, $500/month plus utilities. For Share, $300/month including utilities. Call 201-846-1661 or 201-572-7553.

OFFICE FOR RENT—Fully equipped office used for primary female care by a husband-wife team, available at once due to illness. Phone ringing actively by patients who want to be seen. Wonderful opportunity to get fast start in practice in a good town on public transportation route. Call Jon Wilson at 201-356-6263 for particulars.

OFFICE SPACE—Chatham. Professional offices in fine residential community. Tri-county line, Essex, Union, Morris Counties. Near Overlook Hospital. Now available, call 201-635-8455 or in evenings 201-992-8886.

OFFICE SPACE—Professional office for rent in West New York. Corner location with parking; on Doctor's row. Close to hospital and public transportation. Call 201-278-1000 or 201-947-4333.

OFFICE TO SHARE—Morristown, central location. Near hospital, fully equipped, newly decorated. All utilities included. Ample parking available. Near public transportation. Available immediately 201-267-2555.

OFFICE TO SHARE—Westfield, central location, near hospital, fully equipped, attractively decorated. All utilities included. Ample parking available. Near public transportation. Available immediately 201-233-5800.

RATE INFORMATION FOR MEMBERS: $5.00 per insertion up to 25 words; 10 cents each additional word. Payable in advance. **WORD COUNT:** Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one word, and "Write Box No. 000, c/o JMSNJ" as six words. **COPY DEADLINE:** Fifth of preceding month.

Note: If you're new to medical practice in N.J. . . .

You don't have to buy commercial malpractice insurance

JAMES S. TODD, M.D., *Chairman/Board of Directors, Medical Inter-Insurance Exchange of New Jersey*

AS you made your decision to establish yourself in New Jersey, you no doubt heard horror stories about our professional liability insurance problems. The legal risks we assume in this business have grown so far out of proportion that many commercial underwriters have been simply unable to cope, resulting in abrupt and often untimely suspension of coverage.

As a new practitioner in this State, either relocating or just beginning your professional career, you have an alternative to commercial insurance. The Medical Inter-Insurance Exchange provides an opportunity to build your new practice on the most secure footing possible with long-term peace of mind.

Founded in 1977 at the peak of the "premium crisis," the Exchange is a wholly doctor-owned cooperative organization through which we insure *ourselves* for our own sake. Membership has grown to two-thirds of all practicing physicians and surgeons in the state. Because we're in it for security — *not for profit* — we can provide for ourselves the absolute best available insurance product for the money. Every dollar we take in goes toward protection (no sales commissions) and every dollar left over is returned to us — in cash.

You owe it to yourself to know your options and the practicalities of each. We're here to help you sort them all out. Call and talk directly to our Vice President and Director of Policyholder Services, Bill Reilly, **TOLL FREE (in N.J.) 800-257-6288** or (609) 896-2404 from other areas. We look forward to hearing from you.

A professional service message from the **Medical Inter-Insurance Exchange** of N.J.
Two Princess Road, Lawrenceville NJ 08648
(609) 896-2404



PHYSICIAN PROMOTE THYSELF!*

We're ***IMPACT COMMUNICATIONS*** and we can help you do just that. During the past six years, we've pioneered the business of promoting and marketing medical practices throughout the State. Whether your practice is small or large, established or new, we can provide you with discreet and effective public relations and marketing services at very reasonable rates.

Our Services Include:

- Broadcast interviews (TV, radio, cable)
- Articles and news releases
- Community speaking engagements
- Advertising
- Direct mail
- Office brochures
- Patient handouts and newsletters
- Video-tape presentations
- Employee communications

Call us today for an initial evaluation. We can transform your hard work into headlines!

IMPACT COMMUNICATIONS

2033 Lemoine Avenue
Fort Lee, New Jersey 07024
(201) 947-3777

*with apologies to Aesculapius

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY
JULY 1984

TRANSACTIONS 1984 HOUSE OF DELEGATES 218TH ANNUAL MEETING MAY 3-6, 1984

LIBRARY
U.C. SAN FRANCISCO
AUG 2 1984

The Library
Acquisitions Division
Univ. of Calif., San Francisco
San Francisco, Calif. 94143 S

TRANSACTIONS
1984 HOUSE OF DELEGATES

1983 TRANSACTIONS

At its first session on May 3, 1984, the House of Delegates approved the Transactions of the 1983 House of Delegat as published in the July 1983, Transactions of *The Journal.*

ACTION TO LIMIT DEBATE

At its first session on May 3, 1984, the House of Delegates agreed, upon motion, that no one may speak more tha once on any given subject except in rebuttal or by express permission of the House, and that floor time in eac instance shall be limited to four minutes unless exception is made by the House.

REPORTS AND RESOLUTIONS

Reports and resolutions and the actions, thereon, are included under the Reference Committee to which they we assigned. The House takes action only on the resolved sections of a resolution.

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

Officers and Trustees

PRESIDENT AND CHAIRMAN OF THE BOARD
Frank Y. Watson, M.D. (Essex) ..... Glen Ridge
PRESIDENT-ELECT
Ralph J. Fioretti, M.D. (Bergen) ..... Rochelle Park
FIRST VICE-PRESIDENT
Edward A. Schauer, M.D. (Monmouth) ..... Farmingdale
SECOND VICE-PRESIDENT
Harry M. Carnes, M.D. (Camden) ..... Audubon
IMMEDIATE PAST-PRESIDENT
Alexander D. Kovacs, M.D. (Union) ..... Scotch Plains
SECRETARY
Arthur Bernstein, M.D. (Essex) ..... South Orange
TREASURER
Paul J. Hirsch, M.D. (Somerset) ..... Bridgewater

Trustees

Joel S. Cherashore, M.D. (1986) (Essex) ..... Nutley
Douglas M. Costabile, M.D. (1987) (Union) ..... Murray Hill
Palma E. Formica, M.D. (1987)
(Middlesex) ..... New Brunswick
Harry W. Fullerton, Jr., M.D. (1985)
(Salem) ..... Carney's Point
Frank Gingerelli, M.D. (1986) (Bergen) ..... Hackensack
Michael M. Heeg, M.D. (1987) (Mercer) ..... Trenton
Louis L. Keeler, M.D. (1985) (Camden) ..... Collingswood
John P. Kengeter, M.D. (1987) (Ocean) ..... Toms River
Edwin W. Messey, M.D. (1985) (Burlington) ..... Willingboro
Myles C. Morrison, Jr., M.D. (1985) (Morris) .... Morristown
John J. Pastore, M.D. (1986) (Cumberland) ..... Vineland
Carl Restivo, Jr., M.D. (1987) (Hudson) ..... Jersey City
Bernard Robins, M.D. (1987) (Essex) ..... Springfield
Gerald H. Rozan, M.D. (1987) (Passaic) ..... Wayne

Councilors

FIRST DISTRICT
(Essex, Morris, Union, and Warren Counties)
Edward M. Coe, M.D. (1987) ..... Cranford
SECOND DISTRICT
(Bergen, Hudson, Passaic, and Sussex Counties)
Robert A. Weinstein, M.D. (1986) ..... Newton
THIRD DISTRICT
(Hunterdon, Mercer, Middlesex, and Somerset Counties)
Louis G. Fares, M.D. (1985) ..... Trenton
FOURTH DISTRICT
(Burlington, Camden, Monmouth, and Ocean Counties)
Frederick W. Durham, M.D. (1987) ..... Haddonfield
FIFTH DISTRICT
(Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties)
Paul H. Steel, M.D. (1986) ..... Atlantic City

AMA Delegates

William J. D'Elia, M.D., *Chairman* (1985) ..... Spring Lake
Alfred A. Alessi, M.D. (1986) ..... Hackensack
Frederick W. Durham, M.D. (1986) ..... Haddonfield
Palma E. Formica, M.D. (1986) ..... New Brunswick
Karl T. Franzoni, M.D. (1986) ..... Trenton
John S. Madara, M.D. (1986) ..... Salem
Henry J. Mineur, M.D. (1986) ..... Cranford
Myles C. Morrison, Jr., M.D. (1985) ..... Morristown
Howard D. Slobodien, M.D. (1985) ..... Metuchen

AMA Trustee

James S. Todd, M.D. (Ridgewood) ..... Bergen

Publication Committee

Paul J. Hirsch, M.D., *Chairman*
Dirck L. Brendlinger, M.D.
Frederick B. Cohen, M.D.
A. Olusegun Fayemi, M.D.
Robert M. MacMillan, M.D.
Leon G. Smith, M.D.
La Verne Fioretti

Editor

Arthur Krosnick, M.D.

Managing Editor

Geraldine R. Hutner

Assistant Managing Editor

Dorothy J. Griffith

Advertising Manager

E. Elizabeth Cookson

Executive Director

Vincent A. Maressa

Executive Director Emeritus

Richard I. Nevin

Editorial Board

Jerome Abrams, M.D. (Obstet/Gynecol)
Joseph Alpert, M.D. (Vasc Surg)
Harold Arlen, M.D. (Otolaryngol)
Alfonse Cinotti, M.D. (Ophthalmol)
Robert Dodelson, M.D. (Nephrol)
Norman H. Ertel, M.D. (Int Med/Endocrinol)
Daniel P. Greenfield, M.D. (Psychiat)
Christine E. Haycock, M.D. (Sports Med)
Monroe S. Karetzky, M.D. (Pulmon Med)
Avrum L. Katcher, M.D. (Pediatr)
Stanley C. Leonberg, Jr., M.D. (Neurol)
Joel D. Levinson, M.D. (Gastroenterol)
Joseph A. Lieberman, III, M.D. (Fam Med)
Henry R. Liss, M.D. (Neurosurg)
Geobel A. Marin, M.D. (Int Med/Gastroenterol)
Donald G. McKaba, M.D. (Allergy)
Robby Meijer, M.D. (Plas Surg)
Frank T. Padberg, Jr., M.D. (Surg)
Christopher A. Papa, M.D. (Dermatol)
Norman Riegel, M.D. (Book Review)
Edwin L. Rothfield, M.D. (Cardiol)
Benjamin F. Rush, Jr., M.D. (Surg)
Morris H. Saffron, M.D. (Med His)
Mark M. Singer, M.D. (Int Med/Endocrinol)
Sheldon D. Solomon, M.D. (Rheum)
Lloyd N. Spindell, M.D. (Radiol)
A. Arthur Sugerman, M.D. (Psychiat)
Stephen F. Wang, M.D. (Pediatr)
Edwin S. Wilson, M.D. (Radiol)
Louis S. Zeiger, M.D. (Nucl Med)
Robert B. Zufall, M.D. (Urol)

The Journal of the Medical Society of New Jersey (ISSN-0025-7524) is published monthly (since 1904) except semimonthly in July (13 issues), under direction of the Committee on Publication, by the Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648. Printed in East Stroudsburg, PA, by the Hughes Printing Co. Whole number of issues 965. Member's subscription ($10) is included in Society dues. Rates for nonmembers, $20; outside USA add $7.50 for postage. Single copies, $2. Address communications to *The Journal* MSNJ, Two Princess Road, Lawrenceville, NJ 08648, (609) 896-1766. Second-class postage paid at Trenton, NJ, and additional entry office. Copyright 1984 by the Medical Society of New Jersey.

INDEX

Topic	Reference Committee	Page
Abortions, Third Trimester—Resolution #17 (1983)	"E"	53
AMA Delegation	"A"	11
AMA Delegation, Composition of—Resolution #2	"Const. & Bylaws"	60
AMA Membership	"B"	19
American Association of Medical Assistants-State of NJ, Inc.—Resolution #8	"D"	48
Amendments to the Bylaws, Proposed	"Const. & Bylaws"	56
Anesthesiologists, NJ State Society of—Resolution of Appreciation		6
Annual Meeting, Committee on	"B"	22
Annual Meeting, Plans for 1985—Resolution #27	"B"	27
Attendance Figures		62
Bernstein, Arthur, M.D.—Resolution of Appreciation		6
Blue Shield Participating Physician Agreements—Resolution #5	"C"	33
Board of Trustees	"A"	8
Board of Trustees, Chairman of the	"A"	13
Cancer Control Coordinating Council	"E"	52
Candidacy for Elective Office	"A"	14
Certificate of Need	"C"	31
Collective-Bargaining Agent for Physicians' Services—Resolution #25	"C"	36
Corporate Restructuring of NJ Hospitals	"C"	28
Credentials, Committee on	"B"	19
Delegates, AMA and Alternate	"A"	13
DRG, Opposition to	"A"	13
DRG Position, Ad Hoc Committee on Presentation of MSNJ	"A"	10
DRGs, Financial Impact of—Resolution #22	"A"	18
DRGs—Health Care—Resolution #21	"A"	18
Driving under the Influence of Alcohol and Other Drugs—Resolution # 1	"E"	54
Drunken Driving—Resolution #7 (1983)	"A"	15
Dues for UMDNJ Faculty	"A"	13
Emeritus Membership, Nominations for	"B"	25
Executive Director	"A"	12
Eye Care Project	"E"	52
Fee Disputes—Resolution #18	"A"	17
Finance and Budget	"B"	23
Franzoni, Karl T., M.D.—Resolution of Endorsement		6
Generic Prescriptions—Resolution #20	"C"	35
Health Care Service, Definition of a	"C"	30
HMOs, Advertising on Behalf of, by U.S. Dept. of Health and Human Services—Resolution #26	"D"	49
Hospital Medical Staff Section	"Const. & Bylaws"	59
Hospital Medical Staff Section, Establishment of a MSNJ—Resolution #10	"Const. & Bylaws"	60
Hospital Staffs in MSNJ House of Delegates, Representation of—Resolution #4	"Const. & Bylaws"	60
Hospitals, Corporate Restructuring of New Jersey	"C"	30
House of Delegates Election		61
Impaired Physicians, Committee on	"A"	15
Inauguration Activities—Resolution #7	"B"	27
JCAH Medical Staff Standards—Resolution #28E	"A"	18
Judicial Council	"A"	11
Laetrile, Prescribing, Administering, or Dispensing	"E"	53
Legal Service Evaluation—Resolution #17	"C"	35
Legal Services Plan	"C"	30
Legislation, Council on	"D"	37
Legislative Service, Expand—Resolution #14	"D"	48
Long-Range Planning and Development, Committee on	"A"	13
Mammography—Resolution #19	"E"	55
Mandatory Assignment—Resolution #24	"C"	36
Mandatory Assignment under Medicare, Opposition to—Resolution #16	"C"	34
Media Techniques Seminar	"D"	47
Medicaid Personal Physician Plan	"C"	30
Medical Emergency Protocol—Resolution #13	"E"	55

Topic	Reference Committee	Page
Medical Services, Council on	"C"	28
Membership Directory	"B"	20
Membership Figures	"B"	19
Membership Study	"A"	13
Mental Health, Council on	"E"	51
New Jersey State Medical Underwriters, Inc.	"C"	32
Nursing Care—Resolution #23	"C"	36
Patient Education Program—Resolution #15	"D"	49
Physical Therapy Licensing Board	"A"	8
Physician Reimbursement	"C"	28
Physician Supply, Future	"D"	48
Premium Discount—Professional Liability Insurance—Resolution #3	"C"	33
Prescriptions for Controlled Substances	"E"	51
President	"A"	7
Private Practice, Definition of	"C"	30
PRO, Ad Hoc Committee on Study of	"A"	10
Pronouncement of Death Regulation, NJ State Board of Medical Examiners—Resolution #29E	"D"	50
Psychiatric Institutions and Mental Health Centers	"E"	51
Public Health, Council on	"E"	52
Public Relations, Council on	"D"	47
Quality of Care Audit of Services under DRG Program—Resolution #11	"A"	17
Reference Committees:		
A		7
B		19
C		28
D		37
E		51
Revision of Constitution and Bylaws		56
Resident Membership	"A"	13
Resolutions:		
#1	"E"	54
#2	"Const. & Bylaws"	60
#3	"C"	33
#4	"Const. & Bylaws"	60
#5	"C"	33
#6	"C"	34
#7	"B"	27
#8	"D"	48
#9	"C"	34
#10	"Const. & Bylaws"	60
#11	"A"	17
#12	"E"	54
#13	"E"	55
#14	"D"	48
#15	"D"	49
#16	"C"	34
#17	"C"	35
#18	"A"	18
#19	"E"	55
#20	"C"	35
#21	"A"	18
#22	"A"	18
#23	"C"	36
#24	"C"	36
#25	"C"	36
#26	"D"	49
#27	"B"	27
#28E	"A"	18
#29E	"D"	50
Secretary	"B"	19
Service Benefits, Verifying Eligibility for—Resolution #6	"C"	34
Somerset County Medical Society—Resolution of Appreciation		6
Specialty Society Representation in MSNJ House of Delegates	"A"	9
State Board of Medical Examiners, Letters of Admonishment	"A"	8
Statewide Health Coordinating Council	"C"	28
Treasurer	"B"	21
Water Pollution—Resolution #12	"E"	54
Windfall Profits, Prevention of—Resolution #9	"C"	34

Resolution of Appreciation

Introduced by: **Board of Trustees**

Whereas, the New Jersey State Society of Anesthesiologists has presented an unrestricted grant to the Board of Trustees of the Medical Society of New Jersey; and

Whereas, the grant will be used by the Society to help offset the expenses of operation of the Medical Society of New Jersey; and

Whereas, the action of the New Jersey State Society of Anesthesiologists gratefully is acknowledged and accepted by the Medical Society of New Jersey as a recognition of the common interest and efforts of these two respected organizations; now therefore be it

Resolved, that the House of Delegates of MSNJ extend to the New Jersey State Society of Anesthesiologists its appreciation and continued cooperation on issues affecting the practice of medicine in New Jersey.

The resolution was adopted by acclamation by the House.

Resolution of Appreciation

Introduced by: **Board of Trustees**

Whereas, the Somerset County Medical Society has presented an unrestricted grant to the Board of Trustees of the Medical Society of New Jersey; and

Whereas, the grant will be used by the Society to help offset the expenses of operation of the Medical Society of New Jersey; and

Whereas, the action of the Somerset County Medical Society gratefully is acknowledged and accepted by the Medical Society of New Jersey as a recognition of the common interest and efforts of these two respected organizations; now therefore be it

Resolved, that the House of Delegates of the Medical Society of New Jersey extends to the Somerset County Medical Society its appreciation and continued cooperation on issues affecting the practice of medicine in New Jersey.

The resolution was adopted by acclamation by the House.

Resolution of Endorsement

Introduced by: **Board of Trustees**

Whereas, Arthur Bernstein, M.D., has been nominated for a position on the Council on Scientific Affairs of the AMA and will be considered by its House of Delegates in June 1984; and

Whereas, Doctor Bernstein has spent many years committed to the scientific and educational improvement of the practice of medicine and is well equipped to serve the AMA and the medical profession; and

Whereas, the Council on Scientific Affairs will be assisted greatly in its deliberations by Doctor Bernstein's decisive and cogent observations and comments; now therefore be it

Resolved, that the Medical Society of New Jersey House of Delegates unanimously endorses the candidacy of Arthur Bernstein, M.D., for election to the AMA Council on Scientific Affairs.

The resolution was adopted by acclamation by the House.

Resolution of Endorsement

Introduced by: **Board of Trustees**

Whereas, Karl T. Franzoni, M.D., has been nominated for a position on the AMA Council on Medical Service, and will be considered by the AMA House of Delegates in June 1984; and

Whereas, Doctor Franzoni is committed to the service of the medical profession, and the preservation and attainment of physician prerogatives and the goals of the private sector; and

Whereas, the Council on Medical Service will be assisted greatly in its efforts and deliberations by the experience, judgment, and dedication of Doctor Franzoni; now therefore be it

Resolved, that the Medical Society of New Jersey House of Delegates unanimously endorses the candidacy of Karl T. Franzoni, M.D., for election to the AMA Council on Medical Service.

The resolution was adopted by acclamation by the House.

Reference Committee "A"

Reports:

PRESIDENT
BOARD OF TRUSTEES
JUDICIAL COUNCIL
AMA DELEGATION
EXECUTIVE DIRECTOR
COMMITTEE ON LONG-RANGE PLANNING AND DEVELOPMENT
COMMITTEE ON IMPAIRED PHYSICIANS
RESOLUTIONS #11, #18, #21, #22, #28E

Members:
Robert E. Steward, M.D., Chairman, Middlesex
Albert M. Doswald, M.D., Somerset
Arthur Ginsburg, M.D., Morris
E. Arthur Kratzman, M.D., Union
Giovanni Lima, M.D., Essex
James E. Brennan, M.D., Alternate Member, Camden (absent)

PRESIDENT

ALEXANDER D. KOVACS, M.D., SCOTCH PLAINS

(Reference Committee "A")

The preparation of an annual report requires a review of the activity of the prior year. I doubt that any president of MSNJ faced with that task ever has been satisfied totally with his accomplishments. There have been setbacks and disappointments. There also has been significant progress toward the goals listed in my inaugural address last May.

In May, I emphasized the necessity of becoming more active politically. Evidence of our success in this area was proved by the healthy increase in JEMPAC membership and outstanding contributions made to MEDAC. In addition to money, it is apparent that many of you did initiate contact with your legislators with positive results. We were able to hold the line on such matters as a fee schedule for auto insurance. We secured an important amendment to the physical therapy bill and helped to defeat the optometry bill. Also, we lost a couple of bills, i.e. **A-784** and **A-785** requiring hospitals and liability insurance carriers to report physicians to the New Jersey State Board of Medical Examiners, but on balance it was a good legislative year. It is important that we continue to develop this relationship. It has been my experience that our legislators truly welcome our input. The more they know about a bill, the more intelligently they vote. It is my hope that this year finally will see some legislative relief in tort reform. The good will of our legislators is crucial to this effort.

There has been some lessening of tension between MSNJ and the New Jersey State Board of Medical Examiners. I believe that the presence of our Trustees and MSNJ staff at their meetings and the unofficial presence of members of the State Board at our Board of Trustees' meetings has contributed to a broader understanding of our respective problems.

There has been an improvement in our relationship with the Commissioner of Health. We do not always agree, of course, but we find Commissioner Goldstein to be forthright in his dealings with us. He has met with us and discussed mutual problems with extraordinary frankness. We were pleased when he indicated his willingness to be flexible in the matter of JCAH-Department of Health Guidelines for hospital inspections. He withdrew proposed medical staff guidelines to give us time to coordinate with JCAH guidelines, thus precluding conflict in this area. In the matter of DRGs, the Commissioner is committed but he has been willing to participate in a dialogue and that is a significant improvement.

It has been an exciting, difficult year. The untiring efforts of the staff, the Trustees, and the membership as a whole have made it a rewarding one.

The Reference Committee **recommends** that the report be filed.

HOUSE ACTION: Filed.

BOARD OF TRUSTEES

DOUGLAS M. COSTABILE, M.D., CHAIRMAN, MURRAY HILL

(Reference Committee "A")

As Chairman of the Board of Trustees, it is a pleasure to give you a synopsis of the trials and tribulations your Board of Trustees has endured since the last meeting of the House of Delegates.

It has been encouraging to see that committees of the Society and specialty societies have closed ranks in an effort to maintain the freedoms of private practice as we know it.

There have been questions about the quality of care under the present DRG reimbursement. To this end, the cochairmen of the Ad Hoc Committee on Presentation of MSNJ DRG Position as well as the Executive Committee have been meeting with the Commissioner of Health to ascertain that quality of care is not reduced while curtailing medical expenses. It appears that New Jersey will maintain its waiver for the next few years.

The Board appreciates the monthly reports from Stanley S. Bergen, Jr., M.D., President of the University of Medicine and Dentistry of New Jersey, who keeps the Society informed as to the progress of the medical schools.

This year the Academy of Medicine of New Jersey has provided the Board with monthly reports which are reviewed. The educational arm of the Medical Society of New Jersey is functioning extremely well.

The continuous dialogue generated from the reports and information presented by Mr. Louis P. Scibetta, President of the New Jersey Hospital Association, is extremely helpful to the Board in its deliberations.

The Medical Society of New Jersey Student Association has shown much interest in both the Medical Society of New Jersey and the AMA. Student representatives have attended the House of Delegates meetings. We welcome their participation and hope that the future will bring more of them into the ranks of organized medicine.

The Health Research and Educational Trust of New Jersey is televising programs to numerous hospitals in the state. It is hoped that every hospital will join as this is another way the members of MSNJ will be informed as to current problems facing medical practice.

I would like to acknowledge and thank the members of the Society who come to the monthly Board meetings. Their input has been valuable in the deliberations of the Board.

Doctor James S. Todd was re-elected as AMA Trustee. He and our delegation to the AMA have served the Medical Society of New Jersey well. We trust that they will continue to work for the betterment of our free enterprise system.

Special thanks to William E. Ryan, M.D., for his tireless effort to keep JEMPAC financially sound. This has been a banner year for contributions, and for the first time physicians have come to realize that political action does help—keep up the good work.

The Board of Trustees acknowledges the work that Mr. Vincent A. Maressa, Ms. Diana Gore, and members of the Medical Society of New Jersey staff have executed so efficiently, making the Board's task easier.

Although we have had many items on the agend during the past year, the Board of Trustees, with ou able President, Alexander D. Kovacs, M.D., has mar aged to act on them in the interest of the Society.

Most of the issues discussed will be set forth in th reports of the President and of the various council and committees.

The Board will continue its efforts for the bes interest of the Medical Society of New Jersey.

I would like to thank the Medical Society and th Board of Trustees for the honor of serving as Chai man this past year.

The Reference Committee **recommends** that the re port be filed.

HOUSE ACTION: Filed.

ISSUANCE OF LETTERS OF ADMONISHMENT B THE STATE BOARD OF MEDICAL EXAMINERS

(Reference Committee "A")

On December 19, 1982, the State Board of Medica Examiners adopted a policy authorizing the Presiden of the State Board to issue letters of admonishmen and criticism to physicians in those instances wher it was determined there was no cause for formal dis ciplinary action, but where the President of the Boar felt the physician's action demonstrated improper con duct. The letters were not to be part of the publi record. Clarification of the propriety of the action c the State Board of Medical Examiners was requeste from the State Attorney General.

A response received from the Attorney General's o fice indicated that a review of the State Board's enab ing legislation and the Uniform Enforcement Act faile to reveal any statutory provision which prohibits th issuance of such letters, and that the issuance of suc letters appears to be consistent with the authorit vested in the State Board. It was concluded that th State Board had not exceeded its authority in adoptin the policy, or that the procedure involves any regu latory overreaching.

It was conceded, however, that subsequent to th request for clarification, the office of the Attorney Gen eral requested the Board to review the procedur further. As a result, the procedure has been modifie and each matter will be reviewed by the State Boar of Medical Examiners and the physician will have th opportunity for a hearing before any letter of ad monishment is issued.

The Reference Committee **recommends** that the re port be filed.

HOUSE ACTION: Filed.

PHYSICAL THERAPY LICENSING BOARD

(Reference Committee "A")

This year Governor Thomas H. Kean signed into law an act which created a Physical Therapy Licensing

Board. One of the appointments to the Board is to be a physician. The Medical Society of New Jersey and the New Jersey Society of Physical Medicine and Rehabilitation were pleased to present for consideration two members of the Society with outstanding credentials in the field of physical medicine and rehabilitation: Bernard Sandler, M.D., and Richard A. Sullivan, M.D.

The Reference Committee **recommends** that the report be filed.

HOUSE ACTION: Filed.

Supplemental Report #1: Board of Trustees

Douglas M. Costabile, M.D., chairman, Murray Hill
(Reference Committee "A")

SPECIALTY SOCIETY REPRESENTATION IN THE MEDICAL SOCIETY OF NEW JERSEY HOUSE OF DELEGATES

Pursuant to the Bylaws, we considered the applications of 26 specialty societies for seating in this House. Thirteen of the societies met the standards established in our Bylaws. We, therefore, recommend that the following specialty societies be granted Delegate status:* New Jersey Dermatological Society; New Jersey Gastroenterological Society; New Jersey Society of Internal Medicine; Neurological Association of New Jersey; New Jersey Neurosurgical Society; Oncology Society of New Jersey; New Jersey Academy of Ophthalmology and Otolaryngology; New Jersey Orthopaedic Society; New Jersey Society of Plastic and Reconstructive Surgeons; Radiological Society of New Jersey; New Jersey Chapter, American College of Surgeons; New Jersey Society of Thoracic Surgeons; and Urologic Society of New Jersey.

The following specialty societies met Bylaw criteria with one exception. They did not establish that 80 percent of their membership are members of the Medical Society of New Jersey. Consequently, they are not recommended for approval. They have been advised to reapply whenever the ratio of their Medical Society of New Jersey membership improves: New Jersey Allergy Society; New Jersey State Society of Anesthesiologists; American College of Chest Physicians, New Jersey Chapter; New Jersey Society of Colon and Rectal Surgeons; American College of Emergency Physicians, New Jersey Chapter; New Jersey Academy of Family Physicians; Nephrology Society of New Jersey; Obstetrical and Gynecological Society of New Jersey; New Jersey Society of Pathologists; American Academy of Pediatrics, New Jersey Chapter; New Jersey Society of Physical Medicine and Rehabilitation; American College of Physicians of New Jersey; and New Jersey Psychiatric Association.

At the first session, the House of Delegates acted as a committee of the whole and approved the seating of the 13 specialty societies and the Medical Society of New Jersey Students Association.

---

*Under the Bylaws, the Medical Society of New Jersey Student Association is considered a specialty society, and its members are recognized as members of the Medical Society of New Jersey.

Supplemental Report #3: Board of Trustees

Douglas M. Costabile, M.D., chairman, Murray Hill

AD HOC COMMITTEE ON PRESENTATION OF MSNJ DRG POSITION

(Reference Committee "A")

The following proposals developed by the Committee were approved by the Board of Trustees:

1. That two or three knowledgeable individuals from outside the state of New Jersey be invited to meet with the Ad Hoc Committee, to discuss concerns about DRGs, as an approach in aiding the Ad Hoc Committee in the presentation of the MSNJ DRG position.

2. That a seminar be held on DRG some time in the early fall, sponsored by the Medical Society of New Jersey.

3. That the Medical Society of New Jersey continue to request an objective investigation of the DRG Program in New Jersey, including necessary legislative activity to further this investigation.

4. That the Medical Society of New Jersey investigate knowledgeable and interested groups to develop alternative methods of pricing or reimbursement, and that the staff be asked to investigate methods of implementation.

5. That recent articles published in *The New York Times* (March 5 and March 18 issues) on DRGs be sent to the membership of the Medical Society of New Jersey, specialty societies, and legislative people throughout the state. The option of whether the articles are sent in complete or summary form is to be at the discretion of staff.

In addition to the articles on DRGs published in *The New York Times* (March 5 and March 18), mentioned in proposal 5, the Reference Committee suggested that response letters on this topic, published in *The New York TImes* on April 2 and April 12, also be included.

The Reference Committee **recommends** that the report be filed.

HOUSE ACTION: Filed.

AD HOC COMMITTEE ON STUDY OF PRO

(Reference Committee "A")

The New Jersey professional standards review organizations now are committed to a PRO Federation, which will present a single PRO bid to the federal government.

Upon the recommendation of the Ad Hoc Committee, the Board approved the establishment of a formal bylaw relationship with the PRO Federation, including the Medical Society of New Jersey, and the New Jersey Association of Osteopathic Physicians and Surgeons, and that there be official representation on the board of trustees of the PRO Federation (or that some similar relationship be advanced.)

The Reference Committee **recommends** that the report be filed.

HOUSE ACTION: Filed.

Judicial Council

Frederick W. Durham, M.D., chairman, Haddonfield

(Reference Committee "A")

From official reports, the Judicial Council presents a summary of its operations and those of county judicial committees for the period May 1, 1983, through March 21, 1984.

By Judicial Committees

Complaints reported as disposed of	36
Alleging:	
Dissatisfaction concerning fees	15
Unprofessional conduct	5
Dissatisfaction with services rendered	10
Dissatisfaction concerning professional ethics	6

By Judicial Council

Meetings held	4
Official communications acted upon	150
Appeal hearings requested	4
Appeal hearings granted	2
Formal opinions rendered	0

Of the four requests for appeal hearings, two were denied after careful review of the records indicated that the county judicial committees had been presented with all the relevant and material facts necessary to make a determination; two cases were heard on appeal, one was remanded to the county judicial committee for a "formal hearing" and the other disposition resulted in a 60-day suspension from the county society with notification to insurance companies and the option of the county society to make the suspension public.

Seldom in the past 15 years has the Judicial Council reviewed cases where the penalty involved suspension or expulsion from a component society. We have been presented with two such cases this year.

Procedural errors continue to produce a number of appeals. Investigation has disclosed that some county judicial committees disregard the requirement that all principals involved be invited to be present and to participate in the hearings that are mandated whenever an amicable settlement proves impossible of accomplishment.

The Council urges that each judicial committee strive to improve its procedures in these regards. Therefore, the committees again are reminded to follow the directions contained and the procedural steps outlined in the *Rules and Regulations for the Processing of Grievances and Complaints.*

The Council has adopted the policy that whenever a county judicial committee's disposition is referred to the State Board of Medical Examiners an appeal hearing will be granted. The only time this will not be done is when the evidence shows that immediate action is necessary.

The Council takes this opportunity to emphasize that decisions of judicial committees of component societies are binding upon all members. The judicial mechanism is one of the modalities being used to preserve the good name of medicine and to buttress and support the professional accountability of the membership.

The Reference Committee **recommends** that the report be filed.

HOUSE ACTION: Filed.

AMA Delegation

William J. D'Elia, M.D., chairman, Spring Lake

(Reference Committee "A")

The American Medical Association Delegation of the Medical Society of New Jersey is pleased to submit this annual report.

The Delegation, consisting of nine delegates and nine alternate delegates, has worked conscientiously and diligently, faithfully attending all meetings and serving on important committees and in responsible positions. The AMA House of Delegates meets on two occasions, the Annual Meeting in June, and the Interim Meeting in December. Our members serve on various reference committees, regularly appear before reference committees, give testimony, and take an active part in the deliberations of the House of Delegates. We have made great progress over the year, particularly in developing increasing respect and recognition throughout the House.

A major item before the AMA House during its Annual and Interim Meetings was the revision of the standards of the Joint Commission on Accreditation of Hospitals. Our Delegation presented Resolution #11 (1983 MSNJ Annual Meeting), wherein MSNJ strongly opposed the implementation of proposed changes by the Joint Commission on Accreditation of Hospitals because they would lead to a decrease in the quality of care for future hospital patients. This was presented with the understanding that the Society's position was to preserve the pre-eminence of physician control of hospital staff management and medical policies within the hospital structure.

We presented a resolution on the establishment of impaired physicians programs. It was recommended in the resolve that the AMA urge each state medical so-

ciety to commit significant resources for impaired physicians programs that are based on the successful elements of already established programs, and, further, that the AMA participate in this process by retaining part-time regional consultants to facilitate and coordinate such program development by the state medical societies. This was well received and is under study. The AMA Sixth National Conference on the Impaired Physician will be held on September 5 to 8, 1984, at the Meadowlands Hilton, in Secaucus. This meeting will be cosponsored by the Medical Society of New Jersey. New Jersey is recognized as a national leader in attempting to resolve the problem of the impaired physician.

We brought to the AMA our opposition to the concept of DRGs. The AMA has begun to accept our viewpoint and is moving closer to uniformity with the Medical Society of New Jersey.

At the June 1983 Annual Meeting, James S. Todd M.D., was re-elected to his second term on the AMA Board of Trustees. The entire Delegation devoted considerable time working on his candidacy, contacting various delegates throughout the country, attending various meetings, making personal contacts, and hosting the AMA delegates' reception in his honor. Doctor Todd was re-elected by a sizeable majority and we are proud to have him on the Board of Trustees.

During the past year, the Delegation formed a Policymaking Subcommittee for Internal Affairs. A handbook establishing guidelines for the operation of the Delegation resulted in a more efficient, coordinated organization.

The Reference Committee **recommends** that the report be filed.

HOUSE ACTION: Filed.

Executive Director

Vincent A. Maressa, Lawrenceville

(Reference Committee "A")

Legislative issues on the federal and state level predominated Society activities this past year and will continue to do so. The questions of a medical fee schedule under no-fault, tort reform, expansion of limited licenses, and the Department of Health's proposal to incorporate the private practice of medicine in the certificate of need process all remain on the state agenda. Meanwhile, the federal government continues to pursue the concept of mandatory assignment under Medicare and reimbursement to physicians by DRG.

Little progress has been made with the Department of Health in resolving the DRG issue. There is a growing recognition, however, that very substantial problems continue to exist and new problems continue to appear. It almost seems as if the DRG program is New Jersey's Lebanon.

I have begun discussions with high-level personnel in the Department of Human Services regarding realistic reimbursement under Medicaid. The fact that the door has opened is encouraging, and I will continue to pursue that goal.

Dues-paying membership continues to remain a problem which adversely impacts the Medical Society of New Jersey's financial position. We are raising and expanding non-dues income. That is not enough. The Medical Society of New Jersey has a significant share of the New Jersey physician market, but still there are 2,000 to 4,000 potential members outside the Society. The county societies and the Medical Society of New Jersey aggressively are recruiting new members. We have not seen the net results of this activity, but the past four months have indicated a positive growth trend in new members.

The staff of the Society stands ready to implement your policy to the fullest extent of our capabilities.

The Reference Committee **recommends** that the report be filed.

HOUSE ACTION: Filed.

Committee on Long-Range Planning and Development

Bernard Robins, M.D., Springfield
Reference Committee "A")

The Committee met three times during the administrative year and studied a number of significant topics.

Resident Physician Membership: Resolution #9-1983 Annual Meeting

The resolution was referred for review by us. Our report to the Board of Trustees stated that resident membership should be through the county medical society and that the counties should be urged to include resident members in their delegations.

Candidates for AMA Delegate and Alternate Delegate

The Committee was asked to review the selection criteria applicable to AMA delegates and alternates. There are no stipulated requirements other than membership for those or any other positions within the Medical Society of New Jersey. The Committee assumed that the Nominating Committee had been applying the same concepts for those positions as other Medical Society of New Jersey offices. We concluded, however, that membership on the AMA delegation does require unique ambassadorial and articulation skills. The policy of MSNJ and the sentiments of the membership must be explained to persons not familiar with our specific situation. Additionally, a portion of the delegation's function is to provide physicians for AMA leadership positions. Our report was approved by the Board of Trustees and is being passed on to the Nominating Committee. It requests consideration of the issues raised.

Medical School Faculty Section

We were asked to consider whether a special section should be formed so that faculty could be admitted directly to the Medical Society of New Jersey. We advised the Board that faculty members should be viewed as other physician members. They should belong to both the county society and the Medical Society of New Jersey. The Board concurred with our decision.

Chairman of the Board of Trustees

The current Bylaws of the Society provide that an elected trustee shall serve as Chairman of the Board. This creates a confusing structure since the President is the elected leader of the society. Thus, there are two chief executive officers." Confusion often is evidenced by third parties that wish to meet with or negotiate with the Medical Society of New Jersey. We felt a more effective, clear, and streamlined approach would be to have the President serve as the Chairman of the Board and consequently be the sole chief executive officer. The Board of Trustees approved our report and directed the Committee on Revision of Constitution and Bylaws to prepare the appropriate amendments.

Opposition to DRG

The Medical Society of New Jersey has been a voice crying in the wilderness in its opposition to the DRG method of reimbursement. The Committee evaluated the benefits and pitfalls of the Society's position and the potential long-term impact on the Medical Society of New Jersey. The Committee has determined that MSNJ has taken an unpopular but correct position. The interests of the people of New Jersey and our physician members require the Society to continue to oppose the DRG reimbursement. We suggested to the Board that the Ad Hoc Committee which has been presenting the viewpoint of the House of Delegates should continue its concentrated educational effort through techniques directed to physicians and the public alike.

Dues Discount for UMDNJ Faculty

The Committee felt that full-time faculty members with less than six years of service should be given a 25 percent dues discount. This would not apply to department chairmen or other senior positions within the faculty or administration. The Board did not favor this proposal and it was disapproved.

Demographic Study of MSNJ Membership

A computer review of the Society's master file indicated potential physician shortfalls in certain specialties. The specialty societies have been asked to review the demographics of their membership to ascertain whether our observations are compatible.

Direct Candidacy for Elective Office: Substitute Resolution #5-1983 Annual Meeting

This resolution called for a study on alternate methods for the nomination and election of officers and trustees. We reviewed a wide range of formats in both medical and nonmedical societies and associations, and also a report by a consulting firm. Our first report to the Board was returned by the Trustees with a request for clarification. We reconsidered the matter and amended our report. It was presented to the Trustees in February. It calls for the Nominating Committee to develop a slate of two candidates for all officer and trustee positions.

Composition of the Board of Trustees

The Committee filed a report with the Board suggesting that the election of trustees be removed from the House of Delegates. We called for a change to an appointed Board whereby each county society would elect or appoint one trustee. Additionally, any county with more than 750 members would be entitled to appoint one additional trustee. The Board of Trustees did not approve our report.

The Committee would appreciate the comments of the reference committee and members of the House on this idea, since we think it will afford a more demo-

cratic and representative process by which to select trustees.

ADMINISTRATIVE COUNCILS AND COMMITTEES

We have begun a review of the council and committee structure of the Society and will be forwarding a report to the Board of Trustees for action in the 1984 to 1985 administrative year.

The Reference Committee **recommends** that the report be filed.

HOUSE ACTION: Filed.

Supplemental Report: Special Committee on Long-Range Planning and Development

Bernard Robins, M.D., chairman, Springfield

(Reference Committee "A")

DIRECT CANDIDACY FOR ELECTIVE OFFICE

Our report to the Board in regard to an open election process called for the Nominating Committee to present a ballot containing two nominees for the elected officer positions within the Society. In this fashion, we believed the House could be offered more of a selection, but at the same time we could preserve the advantages of using the Nominating Committee concept.

Since the report was far-reaching, we suggested to the Board that they consider it on an office-by-office basis. The Board concluded that the change we proposed was too far-reaching but might be worthwhile if "phased-in," beginning with the Judicial Council. Listed below are the recommendations we presented to the Board, and the Board action on them. Should the House wish to adopt the action of the Board in whole or part it may do so by specific action on the items detailed below.

That the Nominating Committee develop a slate of candidates for the following positions:

(a) Two candidates for the position of Judicial Councilor. The recommendation was approved by the Board.

(b) Two candidates for the position of Treasurer. The majority of the Board was not in favor of the recommendation and it was disapproved.

(c) Two candidates for the position of Secretary. The majority of the Board was not in favor of the recommendation and it was disapproved.

(d) Two candidates for the position of Second Vice-President. The majority of the Board was not in favor of the recommendation and it was disapproved.

(e) Two candidates for the position of First Vice-President. The Board unanimously disapproved the recommendation.

(f) Two candidates for the position of President-Elect. The Board unanimously disapproved the recommendation.

(g) Two candidates for each Trustee position. The Board was not in favor of the recommendation.

The Reference Committee **recommends** that the Nominating Committee may nominate two candidates for each of the following positions: Judicial Councilor, Treasurer, Secretary, and Second Vice-President.

HOUSE ACTION: Approved.

Committee on Impaired Physicians

Boris G. Ivovich, M.D., chairman, clinton
(Reference Committee "A")

The Impaired Physicians Program now is well into its sixth year of operation. New Jersey's Program, under the direction of David I. Canavan, M.D., remains prominent as a model for other organizations to follow.

In September 1983, Dr. Canavan submitted to the Board of Trustees a precise report on activities and accomplishments from September 7, 1982, to September 7, 1983. This report appeared in the December 1983 issue of *The Journal.*

The following highlights the major activities of the Medical Director and the Committee during the past year:

1. Referral from the 1983 House of Delegates: Resolution #7—Drunken Driving. The 1983 House of Delegates referred Resolution #7 to the Committee on Impaired Physicians and to the Committee on Drug and Alcohol Abuse for discussion and report back to the 1983 House of Delegates.

The Committee was in agreement with the intent of this Resolution; however, the Committee felt that it did not encompass the entire problem (i.e. alcohol is one of many mood-altering substances that impairs drivers) and that the resolution should not be restricted to the use of alcohol. The Committee was of the opinion also that this resolution falls more properly under the charge to the Committee on Drug and Alcohol Abuse and should be dealt with there.

The following is the final position taken by this Committee regarding Resolution #7—Drunken Driving: a. that the Committee on Drug and Alcohol Abuse is the appropriate means by which to have such a resolution implemented; b. that this Committee's recommendations regarding the expansion of the resolution be forwarded to the Committee on Drug and Alcohol Abuse; and c. that the Committee on Drug and Alcohol Abuse be apprised of this Committee's support for adoption of an expanded resolution.

2. New Jersey Association of Osteopathic Physicians and Surgeons. The House of Delegates of the New Jersey Association of Osteopathic Physicians and Surgeons voted to submit annually $7,500 for the next three years to the Impaired Physicians Program. It should be noted that proportionate to the number of osteopathic physicians in New Jersey, this was a substantial contribution on the part of NJAOPS.

3. New Jersey Veterinary Medical Association. With the approval of the Board of Trustees, the Impaired Physicians Program has entered into an agreement with the New Jersey Veterinary Medical Association in which NJVMA will contribute $5,000 to the Impaired Physicians Program on a one-year, trial basis. This arrangement will be reviewed by both organizations after one year to ascertain the desirability and practicality of renewing the contract.

4. Urine Monitoring Program. Through the cooperation of the New Jersey Department of Health, we have established a program for ongoing urine monitoring for our substance-abusing clients. Urine is collected under supervision, forwarded to the Department of Health laboratory, using a code number, and reported to MSNJ headquarters. The cost to the physician client is $7 per specimen. The randomicity of testing is controlled through the Medical Director's office. Urine monitoring provides three benefits: a. it is a constant reminder that the physician is being observed; b. it is an effective "early-warning" system; and c. it is invaluable evidence of the drug-free state for future use in defending the physician's recovery before administrative or disciplinary boards.

5. Malpractice Experience Review. A confidential study was conducted through the Medical Director's office of the experience of the malpractice carriers in claims against "impaired" physicians as compared to those who were not known to be impaired. Preliminary data from MIIENJ suggest that in the "impaired group" there was a 30 percent higher incidence of claims.

6. Statement of the Problem. The statement of the problem has been approved as an official document of the Impaired Physicians Program. It outlines the Program's purpose, organization, policies, and objectives. Copies of the statement are available through the Medical Director's office. It also is planned to distribute this statement to all New Jersey hospitals.

7. Treatment Loan Fund. In my last report to the House of Delegates, I reported on the Medical Director's activities in establishing a Treatment Loan Fund to be used to assist our clients in meeting treatment or living expenses during their absence from practice. Contributions to the Treatment Loan Fund to date are as follows:

Drug Company	Grant	Future Pledge
Warner-Lambert	$10,000	$10,000
E.R. Squibb & Sons	250	—
American Home Products	1,000	—
Merck & Company	5,000	—
Sandoz, Inc.	3,000	7,000
	$19,250	$17,000

The pharmaceutical houses indicated to Dr. Canavan that they would be more responsive to a request for contributions to the Treatment Loan Fund if the physicians were requested to make contributions as well. The Committee recommended, and the Board of Trustees approved, that the Impaired Physicians Program be authorized to solicit voluntary contributions to the Treatment Loan Fund through *The Journal.*

8. Statistical Report—September 7, 1982, to December 30, 1983. The following is a detailed statistical report of the clients involved thus far in the Impaired Physicians Program:

(a) Case load	128 physicians
New cases (81 in 1983)	104
Old cases	24
M.D.	108
D.O.	15
Students	2
DPM	1

DVM 1
Ph.D. (UMDNJ) 1
Male 123
Female 5

(b) Impairment
I. Substance abuse

Alcohol alone	46	35.7%
Alcohol/drugs	20	15.5%
Drugs alone	29	23.3%
	95	74.5%
II. Psychiatric	24	18.6%
III. Senility	6	4.6%
IV. Other	3	2.3%
	33	25.5%

(c) Awaiting confrontation/confirmation 16

(d) Hospitalized
Detox/rehab 43
Psychiatric 12

(e) Present practice status
Active 93
Seeking employment 5
Disabled/retired 15
License suspended 3
License revoked 7
Unable to locate 3
Deceased 2

(f) Referred to State Board of
Medical Examiners 7
License revoked (psych) 2
License suspended 2
License retired (senility) 3

(g) Advocacy
New Jersey State Board of
Medical Examiners appearances 14
Letters of support (NJSBME) 9
Hospital staff committees 13
Court 1

9. Policy Position—Relapse of Clients and/or Committee Members. The following position statement was adopted by the Committee on Impaired Physicians: Relapses in clients must be dealt with on an individual basis and the appropriate reinstitution of therapy should be tailored to the needs of the individual. It was agreed further that relapses of Committee members must be dealt with on an individual basis. The specific action to be determined by the nature, duration, and extent of the relapse and the individual physician's prior period of recovery.

The Reference Committee suggested that anyone interested in serving on the Committee for Impaired Physicians should make it known to the President of the Society.

The Reference Committee **recommends** that the report be filed.

HOUSE ACTION: Filed.

RESOLUTION #11

Introduced by: **Robert J. Weierman, M.D., Delegate, Essex County**
Subject: **Quality of Care Audit of Services Rendered Under the DRG Program**
Referred to: **Reference Committee "A"**

Whereas, the state of New Jersey has been quoted across the nation as the leader in DRG; and

Whereas, there is no credible data in New Jersey concerning the impact of DRGs on patient care; now therefore be it

Resolved, that the Medical Society of New Jersey's Board of Trustees continue to request the New Jersey Department of Health to authorize a quality of care audit of services rendered under the DRG Program; and be it further

Resolved, that the study be conducted by recognized medical and surgical organizations that are external to the New Jersey DRG Program.*

The Reference Committee **recommends** that Resolution #11 be adopted.

HOUSE ACTION: Adopted.

*Note: The president of the Medical Society of New Jersey has recommended to the Commissioner of Health that such a study be conducted by the American College of Physicians and the American College of Surgeons. The specific points to be covered already have been transmitted to the Commissioner.

RESOLUTION #18

Introduced by: **Morris County Medical Society**
Subject: **Arbitration of Fee Disputes by County Medical Societies**
Referred to: **Reference Committee "A"**

Whereas, the traditional recipient and arbitor of physician fee disputes is, and properly should be, the county medical societies; and

Whereas, the New Jersey State Board of Medical Examiners has enacted Excessive Fee Review Committees; and

Whereas, all fee complaints may be evaluated properly by county societies, whether initially received by that society or by the State Board of Medical Examiners; and

Whereas, the effective function of such fee review by component societies would be enhanced by standardization of the review process; now therefore be it

Resolved, that the Medical Society of New Jersey direct all county societies to adopt a standardized fee review committee procedure in keeping with Judicial Council Opinion No. 29, dated January 21, 1981; and be it further

Resolved, that an additional protocol be established to allow review of fee complaints against physicians made to the State Board of Medical Examiners when such complaints are forwarded by the respondent (defendant) physician.

The Reference Committee recommends that the first resolved be amended to read as follows:

Resolved, that the Medical Society of New Jersey remind all county societies that they must conform to the judicial mechanism as outlined in the Judicial Council Opinion No. 29 (January 21, 1981) when dealing with excessive fee disputes; and be it further*

The Reference Committee **recommends** that Resolution #18 be adopted as amended.

The Reference Committee added that all physicians involved in fee disputes who are not members of the state or county medical societies should have their disputes referred directly to the State Board of Medical Examiners.

HOUSE ACTION: Adopted as amended.

*Opinion of the Judicial Council, re jurisdiction of fee review committees: A number of inquiries have been received by the Judicial Council regarding the appropriateness of establishing "Fee Review Committees." The Judicial Council requested Legal Counsel to advise us in this regard since there are questions related to antitrust and the Federal Trade Commission. Legal counsel has advised that questions and complaints regarding fees are specifically within the jurisdiction of the Judicial Mechanism of the Medical Society of New Jersey and the Judicial Committees of the Component Societies and should be treated accordingly as questions of ethics and professional conduct. County Society Judicial Committees should conduct themselves accordingly. They, of course, may utilize the opinions of specialists or advisory committees in reaching their determinations.

Resolution #21

Introduced by: **Charles Harris, M.D., Delegate, Ocean County**
Subject: **DRGs—Health Care**
Referred to: **Reference Committee "A"**

Whereas, the impact of DRGs on patient care never has been evaluated; and

Whereas, that impact may be adverse to the best interests of patients and the people of New Jersey; now therefore be it

Resolved, that the Medical Society of New Jersey demand the State Department of Health to maintain true prospective and retrospective statistical data, including death rates and readmission rates, on each patient; and be it further

Resolved, that the above statistics be published on a quarterly basis.

The Reference Committee **recommends** that Resolution #21 be adopted.

HOUSE ACTION: Adopted.

Resolution #22

Introduced by: **Charles Harris, M.D., Delegate, Ocean County**
Subject: **Financial Impact of DRGs**
Referred to: **Reference Committee "A"**

Whereas, there are conflicting reports regarding the financial impact of DRGs; and

Whereas, the Department of Health claims the program is cost effective, while hospitals are collecting revenues on an unprecedented basis; now therefore be it

Resolved, that the Medical Society of New Jersey petition the legislature to require hospitals and the Department of Health to issue true financial figures, including the cost of funding physician review organizations (PROs).

The Reference Committee **recommends** that Resolution #22 be adopted.

HOUSE ACTION: Adopted.

Resolution #28E

Introduced by: **Union County Medical Society**
Subject: **1984 JCAH Medical Staff Standards**
Referred to: **Reference Committee "A"**

Whereas, the *JCAH Accreditation Manual for Hospitals,* Standard III for medical staff in the 1983 edition states, "The medical staff shall develop and adopt bylaws, rules and regulations to establish a framework of self-government and a means of accountability to the governing body"; and

Whereas, the 1984 medical staff standards no longer contain the reference to "self-government"; and

Whereas, the 1983 standard states that, "The medical staff must develop and adopt bylaws, rules and regulations that create an atmosphere and framework within which each staff member can act with reasonable degree of freedom and confidence"; and

Whereas, the 1984 Medical Staff Standards no longer contain the words "atmosphere" and "each"; and

Whereas, the same standards in referring to the medical executive committee states, "The chairman and members should not ordinarily be appointed by the governing body or the chief executive officer"; and

Whereas, the 1984 standards no longer contain this statement; and

Whereas, these omissions could effectively compromise the role of the physician in the determination of medical staff policy; now therefore be it

Resolved, that the Medical Society of New Jersey voice its objection to the 1984 JCAH Medical Staff Standards as being biased against the physician; and be it further

Resolved, that the Medical Society of New Jersey instruct its delegates to the AMA to bring this matter to the attention of the AMA House of Delegates so that the AMA members of the JCAH might institute immediate corrective action, to assure the autonomy of the medical staff within the framework of its accountability to the patient, the community, and the governing board of the hospital.

The Reference Committee **recommends** that Resolution #28E be referred to the Board of Trustees, with the suggestion that the Board of Trustees consider referral to the Hospital Medical Staff Section for study and report to the Board of Trustees.

HOUSE ACTION: Resolution #28E was referred to the Board of Trustees with the understanding that it be referred immediately to the AMA Hospital Medical Staff Section.

REFERENCE COMMITTEE "B"

Reports:
SECRETARY
TREASURER
COMMITTEE ON ANNUAL MEETING
FINANCE AND BUDGET
NOMINATIONS FOR EMERITUS MEMBERSHIP
RESOLUTIONS #7, #27

Members:
Richard H. Sharrett, M.D., Chairman, Union
John W. Holdcraft, M.D., Gloucester
Fred H. Miller, M.D., Atlantic
Thomas E. Potter, M.D., Passaic (absent)
Joseph P. Zawadsky, M.D., Middlesex
Benjamin I. Smolenski, M.D., Alternate Member, Burlington

SECRETARY

ARTHUR BERNSTEIN, M.D., MILLBURN

Reference Committee "B")

The office of the Secretary has continued its usual routines, primarily involving maintenance of membership records, correspondence, minutes of Board of Trustees' meetings, telephone inquiries, and completion of numerous questionnaires originating from various sources.

During the administrative year, the Secretary attended meetings of the Board of Trustees and several committees of which he is chairman, member, or advisor.

MEMBERSHIP (AS OF DECEMBER 31, 1983)

Active:	Paid	7,527	
	Exempt	900	
Resident:	Paid	37	8,464***
*Associate:	Paid		8
**Affiliate:	Paid		96
	Exempt		4
State emeritus			736
Total of above			9,308
State honorary			8
New and reinstated members:			
Active			366
Resident			25
*Associate			6
*Affiliate			2
Change of status			13
Transfers within the state			39
Transfers out-of-state and resignations			54
Members deceased			116
Members dropped			130
Active: a. Nonpayment of dues		99	
b. Did not comply with bylaw requirements regarding continuing medical education		20	
c. New Jersey license revoked		1	
d. New Jersey license suspended		7	
e. New Jersey license retired		1	
**Affiliate (nonpayment of dues)		2	

*Associate membership (nonlicensed in New Jersey) designates interns and residents.
**Affiliate membership physicians who no longer practice in New Jersey.
***Adjusted for transfers out-of-state, resignations, and deaths.

A comparison of December 31, 1983, to December 31, 1982, by county, shows the following net changes of active paid members:

Atlantic	- 11	Gloucester	+ 1	Ocean	+ 4
Bergen	+ 5	Hudson	- 31	Passaic	- 21
Burlington	+ 9	Hunterdon	- 2	Salem	+ 3
Camden	- 6	Mercer	- 7	Somerset	+ 2
Cape May	+ 3	Middlesex	+ 9	Sussex	- 2
Cumberland	- 2	Monmouth	+ 9	Union	+ 11
Essex	- 65	Morris	+ 2	Warren	+ 5

AMA MEMBERSHIP

A total of 8,099 members of MSNJ maintain active membership in the AMA. The Society's representation in the AMA House of Delegates stands at nine delegates—one for each thousand members, or fraction thereof.

CREDENTIALS

The Committee on Credentials throughout the year reviewed and acted upon membership applications and their supporting credentials as submitted through the component societies. The following statistical breakdown reflects the Committee's activities during the period February 15, 1983, through February 14, 1984:

	*Associate Residents	Active	Grand Total
Received:	33	481	514

Reviewed and found:	*Associate Residents	Active	Grand Total
(A) Satisfactory	30	453	483
(B) Unsatisfactory	0	0	0
Pending:	3	26	29
Withdrew:	0	2	2
Grand Total	33	481	514

*Associate membership (nonlicensed in New Jersey) designates interns and residents.

The Committee extends appreciation to the directors and the secretaries of component societies, and to those who assist them, as well as the County Credentials Committees, for their cooperation in processing membership applications. It especially would be helpful to the Credentials Committee of MSNJ if those who process credentials in the component societies would call specific attention to any deficiencies or questionable data being submitted on the application form. This procedure will help insure more accurate and speedy evaluation of credentials. The chairman wishes to thank his Committee members and MSNJ staff fo their diligence and cooperation.

MEMBERSHIP DIRECTORY

The 1983 edition of the *Membership Directory* ha been available for one year. Since the original distribu tion to members, 2,337 copies have been sold to others It is anticipated that data sheets for the 1985 editio will be mailed to members in early summer 1984. You cooperation in returning them promptly greatly will b appreciated.

The subject of the *Membership Directory* stimulate discussion regarding the hospital section of the *Direc tory* and the practice of listing nonmembers of th Medical Society of New Jersey in the medical staff sec tion of the *Directory*. The Reference Committee sug gested that the Board of Trustees seek a solution t this problem.

The Reference Committee **recommends** that the re port be filed.

HOUSE ACTION: Filed.

TREASURER

PAUL J. HIRSCH, M.D., TREASURER, BRIDGEWATER

(Reference Committee "B")

These interim financial statements, prepared in accordance with generally accepted accounting principles, reflect the financial position and results of operations of the Medical Society of New Jersey through January 31, 1984.

Since they are interim statements the figures are unaudited. A complete audit will be conducted of the books of the Society as of May 31, 1984, and an audited report prepared as of that date. A complete audit was made as of May 31, 1983.

Balance Sheet
January 31, 1984
(unaudited)

Assets		
Cash		$ 120,336
Marketable securities—at cost (approximate market)		1,126,777
Accounts receivable—member assessments		853,507
Medical student loans (net allowance for doubtful loans of $30,000)		397,638
Property, plant, and equipment		
Land	$ 150,000	
Building and improvements	2,551,229	
Furniture and fixtures	410,033	
	3,111,262	
Less allowance for depreciation	447,213	2,664,049
Prepaid expenses		48,862
Other assets		60,254
		$5,271,423

Liabilities and Fund Balance	
Accounts payable	$ 95,932
Accrued Annual Meeting cost	75,017
Other accrued expenses	105,141
Assessments collected for AMA	62,918
	339,008
Mortgage payable	1,521,430
Deferred revenue from member assessments	1,890,625
Deferred professional liability assessments	123,088
Deferred revenue—other	37,200
Fund balance	1,360,072
	$5,271,423

Statement of Revenue and Expenses
8 Months Ended January 31, 1984
(unaudited)

Revenue	
Membership dues	$1,197,998
Publication sales and advertising income	170,145
Amortization of professional liability assessments	83,227
Royalty income	83,251
Amortization of Impaired Physician Program	67,909
Investment income	45,956
Rental income	63,245
Annual Meeting	26,736
Other income	31,181
Total revenue	1,769,648

Expenses	
Conferences and meetings	249,010
Member services	449,789
Total program expenses	698,799
General and administrative	833,687
Interest	101,912
Depreciation	67,851
Total expenses	1,702,249
Excess of revenue over expenses	$ 67,399
Fund balance at June 1, 1983	1,292,673
Fund balance at January 31, 1984	$1,360,072

The Reference Committee **recommends** that the report be filed.

HOUSE ACTION: Filed.

Committee on Annual Meeting

Frank R. Romano, Sr., M.D., Chairman, Dunellen

(Reference Committee "B")

The Committee reviewed at great length the numerous comments, requests, and suggestions received from county medical societies and delegates on proposed changes for future annual meetings.

Changes in the format to accommodate the schedule of the House have been accomplished.

The physical setup for the 1984 sessions of the House of Delegates will be the same as in 1982 (Cotillion Ballroom). The Inaugural Reception and Dinner-Dance will be held on Saturday, May 5.

Arrangements have been made to have eight computer companies exhibit and make a presentation at a scientific program.

Insurance exhibits and informational exhibits will be presented in the area adjacent to the ballroom; scientific and computers exhibits will be located in the area between the ballroom and the convention offices.

JEMPAC's Political Forum will be at 5:00 P.M., on Friday, May 4, to be followed by the JEMPAC Wine and Cheese Reception at 5:45 P.M.

The American Association of Medical Assistants, State of New Jersey, Inc. again will sponsor the Message Center to be located in the registration area.

The Advance Convention Program was mailed in early March.

Housing applications were sent to all component medical societies, and copies have appeared in several issues of *The Journal*. We have had a number of difficulties arise regarding housing. Alternate hotels will be utilized since many rooms at Resorts International will be unavailable.

The Board has expressed its displeasure with Resorts's attempt to avoid its contractual responsibility and the overall lack of commitment to convention performance. This situation was referred to staff and the Committee on Annual Meeting with the autho ization to move the meeting if necessary. In respons to the difficulties encountered in attempting to obtai satisfactory accommodations in Atlantic City for th Annual Meeting, the Committee has investigated oth possible sites in New Jersey but has not been succes ful in finding a facility available in New Jersey whic would be suitable for the Society's needs. Contact ha been made with Americana Host Farm Resort, a facili that can provide adequate space and activities to a commodate the Medical Society of New Jersey. It located in Lancaster, Pennsylvania. At its meeting o December 18, 1983, the Board recommended that w negotiate with the Americana Host Farm Resort an Conference Center, in Lancaster, Pennsylvania, and a cept the dates of May 2 to 5, 1985.

RECOMMENDATIONS

1. That the daily schedule for the 219th Annua Meeting follows closely that which was approved fc the 218th Annual Meeting.*

2. That the 219th Annual Meeting be held at th Americana Host Farm Resort and Conference Cente in Lancaster, Pennsylvania, Thursday to Sunday, Ma 2 to May 5, 1985.

The Reference Committee **recommends** that the rec ommendations be approved.

HOUSE ACTION: Adopted as amended (see foot note).

The Reference Committee **recommends** that the re port be filed.

HOUSE ACTION: Filed.

*Approved, with the exception that at least three referenc committees be dealt with on Saturday afternoon.

Finance and Budget

William Greifinger, M.D., Chairman, Belleville

Reference Committee "B")

The Committee on Finance and Budget met on Wednesday, April 4, 1984, for the purpose of reviewing the proposed budget for the 1984 to 1985 fiscal year. The proposed budget and the following recommendations were approved by the Board of Trustees on April 15, 1984, and are submitted to the House of Delegates for approval.

Recommendations

(1) That the budget for the fiscal year beginning June 1, 1984, and ending May 31, 1985, in the amount of $2,783,400 with $2,062,500 to be raised through member assessments be adopted.

(2) That the 1985 assessment be set at $275 per regular dues-paying member. (No change)

(3) That the 1985 assessment be set at $25 per member for affiliate (no longer practicing in New Jersey) and associate members (interns—residents nonlicensed in New Jersey). (No change)

(4) That there be an assessment for 1985 of $25 per member for licensed residents provided the individual is in a residency program entered upon within a reasonable time after his or her graduation from medical school. (No change)

(5) That the 1985 assessment be set at $10 per student for medical students. (No change)

Statement of Revenue and Expenses for Proposed Budget
Fiscal Year Ending May 31, 1985

Revenue (other than member assessments)		
Publication sales and advertising income		$ 183,900
Amortization of professional liability assessments		96,000
Amortization of Impaired Physicians Program		170,000
Investment income		45,000
Royalty income		90,000
Rental income		96,000
Annual Meeting		5,000
Membership Directory sales		30,000
Other income		5,000
	Total Revenue	720,900
Expenses		
Conferences and meetings		393,200
Member services		453,000
Publications		251,040
Grant to MSNJ Medical Student Loan Fund		3,000
	Total Program Expenses	1,100,240
General and administrative		1,419,860
Interest		150,300
Depreciation		113,000
	Total Expenses	2,783,400
Amount of expenses over revenue to be raised thru member assessments (including *The Journal* subscription and Annual Meeting assessment)		$2,062,500

Revenue from Member Assessments
Fiscal Year Ending May 31, 1985

$275 x 7,500 members	$2,062,500

Proposed Budget
Fiscal Year Ending May 31, 1985

	Approved Budget 1983/84	Estimate for Y/E 5/31/84	Proposed Budget 1984/85
Compensation			
Salaries	$ 755,700	$ 738,641	$ 793,000
Pension plan	105,000	95,933	102,700
	860,700	834,574	895,700
Professional			
Audit	15,000	15,000	16,500
Legal	17,000	14,000	65,000
Actuarial	1,500	1,500	1,800
Special consultants	9,000	6,000	8,000
	42,500	36,500	91,300
Councils and Committees			
Public Relations	120,000	110,000	120,000
Legislation	15,000	21,650	32,000
President & Presidential Officers	37,000	29,000	45,000
AMA Delegates	66,000	89,000	84,000
MSNJ Auxiliary	20,000	16,000	20,000
Medical Education	30,000	27,000	32,000
Board of Trustees	40,000	37,000	20,000
Judicial Council	800	1,700	1,200
Reimbursement of reps. to mtgs.	4,000	3,500	4,000
Other councils and committees	20,000	22,500	20,000
Medical Student Association	14,600	10,500	15,000
	367,400	367,350	393,200
Member Services			
Impaired Physician Program	163,000	144,000	215,000
Annual Meeting	115,000	95,000	105,000
Professional Liability	169,000	110,000	96,000
Membership Directory	30,000	32,000	37,000
	477,000	381,000	453,000
Publication			
The Journal	235,000	260,560	251,040
Donation			
Medical Student Loan Fund	3,000	3,000	3,000
General Administrative and Operating Expenses			
Building operations— (including depreciation)	388,700	374,500	393,300
Insurance	77,000	78,900	95,500
Payroll taxes	63,000	59,000	64,000
Other general office cost	136,160	136,136	143,360
	664,860	648,536	696,160
Total	$2,650,660	$2,531,520	$2,783,400

The Reference Committee **recommends** approval of recommendations 1 through 5.
HOUSE ACTION: Approved.
The Reference Committee **recommends** that the report be filed.
HOUSE ACTION: Filed.

Nominations for Emeritus Membership

(Referenee Committee "B")

The following nominations for eleetion to emeritus membership at the 1984 Annual Meeting have been reeeived from the eomponent societies. Conforming to the provisions of the Bylaws, Chapter I—Membership, Seetion 1—Composition (d), all nominees have been members in good standing of a eomponent society and who by reason of age or infirmity have retired from the aetive praetiee of medieine, or members of this Soeiety who have been disabled by reason of military serviee.

Atlantic County
R. James Dierwechter, M.D., Brigantine; age 72
Morris Gottlieb, M.D., Pomona; age 74
Morton W. Leaeh, M.D., Ventnor City; age 61
Samuel S. Stetzer, M.D., Somers Point; age 52
Walter B. Stewart, M.D., Atlantie City; age 83
Dominie J. Travagline, M.D., Margate City; age 51

Bergen County
Donald E. Brown, M.D., Beverly, MA (formerly Hackensaek); age 66
Kalman Chase, M.D., Sarasota, FL (formerly Ho-Ho-Kus); age 76
Emil Dul, M.D., Garfield; age 68
Gustav Friedmann, M.D., Ridgewood; age 72
Bernard Gliek, M.D., Passaie; age 84
Robert F. Greene, M.D., Treasure Island, FL (formerly Tenafly); age 64
John E. MeWhorter, M.D., Englewood; age 72
Jaeob Prager, M.D., Ann Arbor, MI (formerly Haekensack); age 76
James M. Ruegsegger, M.D., Nyaek, NY (formerly Montvale); age 81
Joseph J. Silber, M.D., Tenafly; age 69
Joseph Speranza, M.D., Beverly, MA (formerly Glen Rock); age 75
Howard C. Tobey, M.D., Ramsey, age 70
Francis P. Twinem, M.D., Sharon, CT (formerly Hackensaek); age 88
Felix H. Vann, M.D., Englewood; age 75

Burlington County
Robert W. Parvin, M.D., Moorestown; age 64
Richard W. Pringle, M.D., Burlington; age 58
Lindley B. Reagan, M.D., Moorestown; age 65
Morris A. Robbins, M.D., Burlington; age 66

Camden County
Riehard C. Goos, M.D., Cherry Hill; age 60
George W. Hager, M.D., Cherry Hill; age 67
Andrew F. Jannett, M.D., Haddonfield; age 60
Eugene H. Kain, M.D., Haddonfield; age 66
Charles O. Tyler, M.D., Island Heights; age 65

Essex County
Lawerence F. Burnett, M.D., Roseland; age 68
Floyd H. Farrant, M.D., Montclair; age 60
Gustav L. Ibranyi, M.D., Newark; age 62
Charles E. Langgard, M.D., Chatham; age 64
Stephen B. Longley, M.D., Maplewood; age 62
John L. Pinderhughes, M.D., Montclair; age 62
Max N. Pusin, M.D., Florham Park; age 66
Geza Seheiber, M.D., Arlington; age 78
Ferdinand G. Weisbrod, M.D., Springfield; age 65
Eugene I. Zins, M.D., Delray, FL (formerly Millburn); age 61

Hudson County
Solomon Arono, M.D., West Orange; age 71
Miehael H. Berman, M.D., Haekensaek; age 64
Adolph D. Caseiano, M.D., Freehold; age 75
Peter J. Cerna, M.D., Kearny; age 53
Theodore H. Elsasser, M.D., North Bergen; age 84
Harry E. Gerner, M.D., Coconut Creek, FL (formerly Jersey City; age 78
Joseph Giannasio, M.D., Union City; age 66
Jaeob A. Riese, M.D., West Palm Beach, FL (formerly Teaneck); age 80
Wolodymyr Zankiw, M.D., Union City; age 66

Mercer County
Raymond E. Miller, M.D., Trenton; age 74

Middlesex County
Mortimer Cowen, M.D., Iselin; age 72
Stephen Jonap, M.D., Deeatur, GA (formerly South Amboy); age 72

Monmouth County
Milton Bregman, M.D., Boynton Beach, FL (formerly Manasquan); age 72
Andrew P. Dediek, Jr., M.D., Little Silver; age 67
Francis J. Mara, M.D., Manasquan; age 62
Franklin L. Reed, Jr., M.D., Rumson; age 69

Morris County
Samuel J. Arnold, M.D., Mendham; age 70
Eugene A. DeFelice, M.D., Morristown; age 56
Robert W. Tilney, Jr., M.D., Far Hills; age 68
James E. Ziegler, M.D., Bernardsville; age 69

Passaic County
David Levy, M.D., Paterson; age 69
Aaron W. Rosendale, M.D., Hawthorne; age 64

Salem County
J. Robert Cox, M.D., Haddonfield; age 76
Wilbur S. Davison, M.D., Pennsville; age 75

Somerset County
Foster J. Datri, M.D., Bridgewater; age 77
James L. Young, M.D., Bound Brook; age 84

Union County
John P. Cannis, M.D., South Plainfield; age 69
Sheldon Fox, M.D., Hillside; age 64
Charles J. Hely, M.D., Westfield; age 70
Edmund A. Johnkins, M.D., Kenilworth; age 61
Theodore Z. Lorene, M.D., Mountainside; age 64
John P. Warter, Jr., M.D., Westfield; age 64
William W. Weissberg, M.D., Elizabeth; age 70
Edward B. Whitesell, M.D., Short Hills; age 64
Ralph Witmer, Jr., M.D., Summit; age 60

The Referenee Committee **recommends** that the nominations be approved.

HOUSE ACTION: Approved.

Supplemental Report #1: Nominations for Emeritus Membership

(Reference Committee "B")

The following additional nominations for election to emeritus membership have been received:

Hudson County
John Schwarz, M.D., Weehawken; age 70

Union County
Joseph E. Mast, M.D., Brielle; age 69

The Reference Committee **recommends** that th nominations be approved.

HOUSE ACTION: Approved.

Supplemental Report #2: Nominations for Emeritus Membership

(Reference Committee "B")

The following additional nominations for election to emeritus membership have been received:

Bergen County
Evelyn E. Dresner, M.D., Hackensack; age 63
John D. Gossel, M.D., Ho-Ho-Kus; age 69
Paul L. Grosner, M.D., Hackensack; age 75
George J. Raskin, M.D., Sierra Golda, MX (formerly Woodcliff Lake); age 77
Simeon Siegel, M.D., New Milford; age 72

Camden County
Ronald M. Bernardin, M.D., West Collingswood; age 65

Essex County
William M. Chase, M.D., Newark; age 64
John H. Hermann, Jr., M.D., Whiting; age 67
Tuhan Kuziw, M.D., Irvington; age 64
Alvin P. Mancusi-Ungaro, M.D., Miami, FL (formerly West Orange); age 63
Chester J. Modeski, M.D., Short Hills; age 70
Maurice M. Rath, M.D., Clearwater, FL (formerly Short Hills); age 70
Wilber F. Taylor, M.D., Bay Head; age 61

The Reference Committee **recommends** that the nominations be approved.

HOUSE ACTION: Approved.

Supplemental Report #3: Nominations For Emeritus Membership

(Reference Committee "B")

The following additional nomination for election to emeritus membership has been received:

Morris County
Edward I. Kessler, M.D., Morristown; age 78

The Reference Committee **recommends** that th nomination be approved.

HOUSE ACTION: Approved.

RESOLUTION #7

Introduced by: **Burlington County Medical Society**
Subject: **Inauguration Activities**
Referred to: **Reference Comittee "B"**

Whereas, the president is the official spokesman for the Medical Society of New Jersey which is composed of 21 component county medical societies; and

Whereas, it is necessary and appropriate that all 21 component county medical societies actively participate in selecting, nominating, electing, and inaugurating a president of the Medical Society of New Jersey; and

Whereas, it is appropriate that the inauguration activities be planned and financed through general funds allocated by the Medical Society of New Jersey; and

Whereas, it is desirable to make the inaugural activities and dinner as appealing as possible toward achieving a large attendance of physicians and guests; now therefore be it

Resolved, that the inauguration activities ~~be~~ planned and arranged by the Medical Society of New Jersey with direct input from the component county medical society from which the president originates; and be it further

Resolved, that the physicians and their guests attending the inauguration dinner be charged only for the actual cost of the meal plus gratuity and tax; and be it further

Resolved, that all other inauguration dinner ~~ex~~penses—including but not limited to the entertainment, orchestra, flowers, special invited guests, printing of invitations, and ~~post~~age—be borne by the Medical Society of New Jersey; and be it further

Resolved, that the inaugural reception which has ~~been~~ in vogue for several years be eliminated.

The Reference Committee discussed Resolution #7 and suggested that the **Resolveds** be amended to read as follows:

Resolved, that the inauguration activities be planned and arranged by MSNJ with input from the component county medical society from which the president originates; and be it further

Resolved, that the physicians and their guests attending the inauguration dinner be charged only for the actual cost of the meal plus gratuity and tax; and be it further

Resolved, that all other inauguration expenses—including but not limited to the entertainment, orchestra, flower, special invited guests, printing of invitations, and postage—be borne by MSNJ.

The Reference Committee **recommends** that Resolution #7 be adopted as amended.

HOUSE ACTION: Adopted as amended.

RESOLUTION #27

Introduced by: **Somerset County Medical Society**
Subject: **Plans for 1985 Annual Meeting**
Referred to: **Reference Committee "B"**

Whereas, plans for the 1985 Annual Meeting of the House of Delegates of the Medical Society of New Jersey are not, in our opinion, consonant with the wishes of the majority of the delegates; now therefore be it

Resolved, that the plans be altered to conform with the four principles listed below:

1. The meeting shall be held in New Jersey.
2. The reference committees shall meet in a staggered sequence, to a reasonable degree, rather than be held simultaneously, so that delegates can attend more than one reference committee.
3. The business portion of the meeting shall take precedence over the scientific portion to ensure that the business portion has a reasonable chance of ending in three days maximum.
4. The scientific portion be scheduled, if necessary, at the beginning or end so that the business ~~session~~ can be concluded in an ~~expeditious~~ manner, hopefully ~~in three~~ days maximum.

The Reference Committee **recommends** that the following Substitute Resolution for Resolution #27 be adopted:

Resolved, that plans for future Medical Society of New Jersey Annual Meetings conform with the two principles listed below:

(1) That the Annual Meeting of the Medical Society of New Jersey be held in New Jersey whenever possible.

(2) That the business portion of the meeting shall take precedence over the scientific portion to ensure that the business portion has a reasonable chance of ending in three (3) days maximum.

HOUSE ACTION: Adopted Substitute Resolution.

Reference Committee "C"

Reports:

COUNCIL ON MEDICAL SERVICES
BOARD OF TRUSTEES' ITEMS
NEW JERSEY STATE MEDICAL UNDERWRITERS, INC.
RESOLUTIONS #3, #5, #6, #9, #16, #17, #20, #23, #24, #25

Members:

Mary T. DiMedio, M.D., Chairman, Salem
Anthony P. Caggiano, M.D., Essex
Michael J. Larkin, M.D., Mercer
Bessie M. Sullivan, M.D., Union
Charles J. Zwerling, M.D., Monmouth
Felix G. Salerno, M.D., Alternate Member, Hunterdon (absent)

Council on Medical Services

JOSEPH FLEISHER, M.D., CHAIRMAN, BAYONNE
(Reference Committee "C")

The Council is charged with the responsibility of studying and evaluating matters relevant to maintenance and advancement of the standards and character of medical practice in New Jersey and the investigation of the economic and social aspects of medical care.

Corporate Restructuring of New Jersey Hospitals. Upon a request from the Board of Trustees, the Council on Medical Services studied a report dated May 27, 1983, of the Statewide Health Coordinating Council's Blue Ribbon Committee on Corporate Restructuring of New Jersey Hospitals. The Council recommended to the Board that the Society object to the fact that it was not asked to have a member participate in the deliberations of the Blue Ribbon Committee, that the Society object to the recommendation contained in the Blue Ribbon Committee's report which recommends broader application of regulatory principles to all providers of health care, and that the Society wishes to participate in any discussions on the development of a definition of "core" hospital services if such a definition is needed. These recommendations already had been accomplished by the Board of Trustees, as affirmed at the Board's meeting on November 20, 1983. The Council also recommended that the Society make a strong statement, with explanations, opposing the application of certificate of need regulations to physicians' private practices. This was approved by the Board of Trustees at its meeting on November 20, 1983. Upon request from the Board of Trustees, the Council is working on an explanatory statement on unbundling, with the understanding that the right of the Medical Society of New Jersey to question unbundling in areas where the activity is considered to be economically unfair is recognized. A report will be forthcoming.

AMA Council on Medical Service Report on Physician Reimbursement. The Council on Medical Services reviewed the AMA Council on Medical Service's recommendation approved by the 1983 AMA House o Delegates regarding the matter of physician reim bursement by means of indemnity versus UCR. It wa reported that the Hudson County Medical Society rec ommended to the AMA a neutral position if the polic favoring the UCR concept is changed. The County als recommends that insurers not be encouraged to adop a general policy of sending checks to patients instea of physicians. The Morris County Medical Society fel the indemnity system of payment for physicians' ser vices recommended in the report should be pursue by the AMA. The Board of Trustees, at its meeting o November 20, 1983, favored the pluralistic approac to physician reimbursement and voted to approve th Council on Medical Services recommendation, a amended by the Board, that the Medical Society of Ne Jersey support pluralistic methods of reimbursemen to include, but not be limited to UCR, private billing and indemnification.

Statewide Health Coordinating Council. The Coun cil on Medical Services recommended that the Medica Society of New Jersey be allowed to designate a rep resentative to the Statewide Health Coordinatin Council (SHCC). This recommendation was approve by the Board of Trustees at its meeting on Novembe 20, 1983.

Resolutions #14, #15, and #16—1983 House o Delegates. The Council, at the request of the Board o Trustees, is in the process of reviewing Resolution #14 (Generic Substitution), #15 (Drug Prices), an #16 (Dispensing of Generic or Brand Name Drugs) from the 1983 House of Delegates. A report will b forthcoming.

The Reference Committee **recommends** that the report be filed.

HOUSE ACTION: Filed.

Supplemental Report #1: Council on Medical Services

Joseph Fleisher, M.D., Chairman, Bayonne

Reference Committee "C")

The following items are reported from the Council n Medical Services meeting on February 29, 1984.

Board of Trustees' Referral—1983 House of Delegates Resolutions #14, #15, and #16

The 1983 House of Delegates considered Resolutions 14—Generic Substitution, #15—Drug Prices, and 16—Dispensing of Generic or Brand Name Drugs, nd determined that they needed further study. The Board of Trustees referred the resolutions to the Council on Medical Services for discussion and report.

The Council has had extended discussions on two eparate occasions, and has heard testimony by Charles Harris, M.D., author of the resolutions. Probems generated by the present generic prescribing requirements including possible adverse effects of generic substitution and problems encountered when prescriptions are telephoned were considered at length by he Council. It was felt that more information is needed efore a proper report can be made. The necessary nformation is being gathered for review by all members of the Council. A full report will be submitted to he Board of Trustees when completed.

Corporate Restructuring of New Jersey Hospitals

Upon the Board of Trustees' request at its meeting n November 20, 1983, in connection with a May 27, 983, report of the Statewide Health Coordinating Council's Blue Ribbon Committee on Corporate Restructuring of New Jersey Hospitals, the Council developed an explanatory statement on unbundling.

The Council defined unbundling as the creation of a for-profit corporation by a primary hospital corporation to which the hospital then transfers a significant asset or service. It was noted that by transferring a money-making operation to an outside corporation, a loss of revenue is created for the hospital which could call for a general rate increase on all hospital services under the DRG system.

It was agreed further that private practitioners cannot compete with hospitals on the basis of hospitals being allowed to subsidize operations in direct competition with physicians with inpatient hospital dollars. Also, the practice of diverting money from the total cost of health care without having to account for it to finance unbundled operations, not returning the revenue from these operations to the hospital, will drive the cost of acute care up and adversely will effect health care and cost containment.

The Board of Trustees, at its meeting on April 15, 1984, approved the Council's recommendation that the Medical Society of New Jersey maintain that assets of hospital corporations which have been and are being unbundled should have those revenues and assets of the unbundled corporations included in the assets and income of the hospital for which the rate development of the hospital itself is based.

The Reference Committee **recommends** that the report be filed.

HOUSE ACTION: Filed.

BOARD OF TRUSTEES' ITEMS

COMPREHENSIVE LEGAL SERVICES PLAN FOR PHYSICIANS

(Reference Committee "C")

The 1981 House of Delegates adopted Resolution #23 which called for the expansion of the current Legal Services Plan to incorporate defense of formal complaints by the State Board of Medical Examiners and review in the Appellate Division. The resolution was referred to the Committee on Medical Defense and Insurance for investigation.

The Committee has been unable to ascertain any legal plan that covers total litigation expense in terms of revocation of licenses. In developing a plan to cover the costs of defending a physician against the revocation or bargained surrender of his license and the consequent loss of his livelihood, the expense of defending a case to the State Supreme Court, if necessary, must be taken into consideration.

It is estimated that under existing frequency levels of activity before the State Board of Medical Examiners at least 80 cases a year will move into the contested area. This may be a conservative estimate because of two laws recently enacted, and the seven deputy attorney generals now working for the State Board.

Two plans were designed as follows, figures for which are based on 2,000 subscribers:

Plan I—Insurance Concept. (a) Open Panel: An open panel insurance concept in which the Society would act as manager or case director using a number of outside law firms. Costs probably would average $15,000 per case, requiring $1.2 million in premiums. Surplus would be required by the Insurance Department which could be $600,000 for a first year of operation. State premium taxes would be approximately $12,000 and administrative costs would be $60,000. The total amount needed to fund this plan would be $1,872,000. The first year premium per member would be $936. (b) Closed Panel: Two or three law firms would be used, under which they may agree to charge $12,000 per case requiring $960,000 in premiums. A surplus of $480,000 would be required; administrative costs for this type of plan would be $40,000, and premium taxes would be $9,600, bringing the total amount needed to $1,489,000. The cost per member would be $744.80, first year.

Plan II—Retainer Concept. Under this plan, one or more law firms would guarantee representation for a set amount annually, regardless of the cost of the cases they handled. The amount of $144,000 would be paid the law firm annually to cover the cost of defense of the first ten cases (with a negotiated formula to be used to reimburse them for extra cases beyond that number), plus $20,000 for administrative costs; $640,000 would be needed based on the 80 cases per year assumption. With this concept, it may be necessary to file with the Department of Insurance, but it may be possible to get a waiver on the requirement for surplus and the payment of premium taxes, as this could be considered a contractual arrangement between the physicians and the attorney, being in effect a prepaid legal service. The cost for this plan per member would be $402.

Analysis. A survey of the Medical Society of N Jersey's membership was conducted to determi interest in joining such a program. The positi responses were less than one-quarter of what is f necessary to offer such a program. Mr. Maressa did n feel that the Medical Society of New Jersey is in t position to expand the existing program because the does not seem to be the level of interest in the membe ship to pay the additional amount required. A full cc erage plan must have no less than 2,000 participan to be viable.

After careful consideration, and as an alternative a comprehensive legal service plan for the Society membership with the belief that some provisic should be made for the defense of deserving cases, t Committee submitted the following recommendatio which was adopted by the Board: That the Board Trustees instructs the Committee on Finance ar Budget to incorporate into the Society's budget a lir item to be used for the defense of meritorious cas before the State Board of Medical Examiners and th the selection of such cases be made on the applicatic of the physician and the review and recommendatic of the Committee on Medical Defense and Insuranc

The Reference Committee **recommends** that the r port be filed.

HOUSE ACTION: Filed.

MEDICAID PERSONAL PHYSICIAN PLAN

(Reference Committee "C")

In December, the Board of Trustees advised the Con missioner of the New Jersey Department of Huma Services that MSNJ does not endorse the Medica Personal Physician Plan being tested in Susse Morris, and Warren Counties.

It is the Board's position that services to Medica patients can be enhanced and costs to the governmer contained by emphasizing medical care in physician offices. This can be achieved by compensating phy sicians in an equitable and realistic fashion for offic treatments.

The Commissioner was urged to reconsider the pilc project on ambulatory care that was developed by th Division of Medical Assistance and Health Services fc testing in Atlantic and Mercer Counties. The progra was presented to the Society by the Division in Sep tember 1980, and has our endorsement.

The Reference Committee **recommends** that the re port be filed.

HOUSE ACTION: Filed.

POSITION OF THE MEDICAL SOCIETY OF NEV JERSEY—DEFINITION OF A HEALTH CARE SER VICE, N.J.S.A. 26:2H-2b

(Reference Committee "C")

The report of the Blue Ribbon Committee on th Corporate Restructuring of New Jersey Hospitals date

ay 27, 1983, and accepted July 29, 1983, was re-
ewed carefully by the Medical Society of New Jersey.
MSNJ noted that the report was conclusionary in
ature and that there was no objective documentation
support the positions established and the rec-
nmendations made therein.

The report asserted that the definition of health care
rvices should be expanded to incorporate the private
actice of medicine because hospitals as regulated
alth care facilities must comply with the certificate
need law while physicians do not. The report as-
med there would be competitive parity if physicians,
erefore, were drawn into the certificate of need legis-
tion. This premise is patently absurd. Most phy-
cians in New Jersey are in practice in settings which
volve one to five persons. The average hospital in New
rsey has 250 inpatient beds, hundreds of employees,
ultimillion dollar operating budgets, and hundreds
millions of dollars in assets, and is exempt from
deral and state taxation.

MSNJ is of the opinion that the certificate of need
w has not worked because it neither is suited for the
rpose intended nor administered in a fashion to be
fective. In a speech before hundreds of people on
ctober 25, 1983, the Commissioner of Health stated
at New Jersey has 30 percent more inpatient beds
an it needs. If that is true, then the law as adminis-
red in New Jersey has been unable to cope with even
bed supply. Further, it should be noted that the current process has not truly addressed financial feasibility in terms of the operation of a proposed facility or service. Until the law and the administration address these two points, no enlargement of jurisdiction is indicated.

Both the Blue Ribbon Committee and the personnel of the Department of Health appear to be confused as to what constitutes the "private practice of medicine." For purposes of certificate of need legislation, the Society offered the following: "Private practice involves those situations where physicians own and utilize a particular piece of equipment in rendering medical services to their patients. It is expected that where equipment requires technical expertise to be properly operated that the physicians will have had special education and training in its use. If any persons other than physicians are investors in the equipment, then it does not constitute private practice. If the physicians who own the equipment do not operate it on behalf of the patients themselves but through employees, they must supervise personally the operation of the equipment."

Private practice as defined above is and should remain exempt from certificate of need legislation.

The Reference Committee **recommends** that the report be filed.

HOUSE ACTION: Filed.

SUPPLEMENTAL REPORT #3: BOARD OF TRUSTEES

OUGLAS A. COSTABILE, M.D., CHAIRMAN, MURRAY HILL

ERTIFICATE OF NEED
(Reference Committee "C")

The Executive Committee met with the Com-
issioner of Health on April 10, to discuss the defi-
ition of a health care facility, and the issue of the
clusion of physicians in the certificate of need pro-
ss.

It was suggested by the Commissioner that the orig-
al proposal of the Department of Health, which set
llar limits, be disregarded and amended to state that
physician would be required to apply for a certificate
need when the service in question has been declared
the Commissioner, through adopted regulations, to
a regionalized service.

The Board concurred with the recommendation of
e Executive Committee to accept the Com-
issioner's proposal, with the provision that a sunset
ause, of reasonable length, be included.

The Reference Committee expressed its concern
out the term "regionalization" and its ramifications,
d the ability of the Commissioner of Health to de-
rmine what is a regionalized service.

The Reference Committee **recommends** that the re-
rt be filed.

HOUSE ACTION: Filed.

LEGAL SERVICES PLAN
(Reference Committee "C")

At its March meeting, the Board postponed, for one month, consideration of a recommendation contained in the report of the Committee on Medical Defense and Insurance, pertaining to the Legal Services Plan, pending receipt of information from Dr. Joseph A. Riggs, as well as input from members of the Plan who have utilized the service.

According to Dr. Riggs, there was a difference between the statistical information in the Committee's report and the records kept by the State Board of Medical Examiners. He suggested that his material be referred to the Committee for their use in future evaluations. It was pointed out that the Committee would be pleased to include the material in its next review.

The Board then approved a recommendation to continue the Legal Services Plan in its present form, since it provides high quality legal services at a modest expense to the members of the Society.

The Reference Committee **recommends** that the report be filed.

HOUSE ACTION: Filed.

New Jersey State Medical Underwriters, Inc.

Vincent A. Maressa, secretary-treasurer, Lawrenceville

(Reference Committee "C")

The Underwriter has completed its seventh year of operations as the Attorney-in-Fact for the Medical Inter-Insurance Exchange of New Jersey. Through the abilities of Mr. Peter Sweetland and his staff, we have managed to prosper in a climate of adversity.

There were 6,947 active insureds at the close of 1983. Subordinated loan redemptions since inception totaled 997, with a cash return of $3,211,200. Total assets stand in excess of $220 million. Paid indemnity during 1983 exceeded $29 million. Aggregated indemnity and expenses stand in excess of $90 million.

A new underwriting format and high-risk program has been developed, and is being refined. An aggressive risk prevention program is in place. A well-received medical-legal correspondence course is in the process of distribution, and several significant loss prevention studies are moving closer to completion. Since 95 percent of our indemnity losses result from settlements prior to trial upon the recommendations of peer reviewers, the conclusion that risk prevention is critical has been accepted by the staff and governors. Our mission now is to create and effect incentives for behavior modification.

We also have designed and will be pursuing a leg lative package of meaningful tort reform. The Und writer and the Society have a reasonable chance to e successful in this regard. The task, however, is n easy, and the cause certainly is not popular beyond te medical profession.

Rates this year increased by 13.7 percent. While th increase is modest by comparison to other states a other times, it does represent a significant rate c ference to other carriers in the New Jersey market. W believe our rate is necessary. It may be conservati but that ultimately works more in your favor than your disadvantage. Since October 1983 there ha been two trial verdicts, each of which exceeded t million dollars. You should consider the placement your liability insurance to be one of the most profou decisions of the financial side of your career. It is a visable to exercise due deliberation in that proces

The Reference Committee **recommends** that the port be filed.

HOUSE ACTION: Filed.

Resolution #3

ntroduced by: **Union County Medical Society**
Subject: **Premium Discount—Professional Liability Insurance**
Referred to: **Reference Committee "C"**

Whereas, premiums for professional liability insurance are increasing steadily; and

Whereas, many physicians are naive about legal processes such as recordkeeping, legal terminology, and so forth, and that lack of sophistication often enhances the credibility of the plaintiff's case; and

Whereas, members of the legal profession attend seminars to increase their understanding of normal and abnormal medical practice; and

Whereas, some professional liability carriers have found it worthwhile to grant a discount on liability premiums for those physicians who attend seminars to increase their knowledge and awareness of legal pitfalls; now therefore be it

Resolved, that the Medical Society of New Jersey, in conjunction with the Medical Inter-Insurance Exchange of New Jersey, be directed to prepare and present appropriate seminars on basic medical-legal matters, charging a reasonable tuition to cover expenses; and be it further

Resolved, that consideration be given by the Medical Inter-Insurance Exchange of New Jersey to provide a discount of premium costs for members of the Medical Society of New Jersey who successfully complete the seminar.

The Reference Committee **recommends** that Resolution #3 be adopted, as amended (italics indicate change), as follows:

Resolved, that the Medical Society of New Jersey, in conjunction with the Medical Inter-Insurance Exchange of New Jersey *and other commercial carriers*, be ~~directed~~ *urged* to prepare and present appropriate seminars on basic medical-legal matters, charging a reasonable tuition to cover expenses; and be it further

Resolved, that consideration be given by the Medical Inter-Insurance Exchange of New Jersey *and other commercial carriers* to provide a discount of premium costs for members of the Medical Society of New Jersey who successfully complete the seminar, *provided it can be demonstrated that such educational programs decrease liability claims against the insured.*

HOUSE ACTION: Referred Resolution #3 and suggested amendment of the Reference Committee to the Board of Trustees for their consideration and advice to the Medical Inter-Insurance Exchange of New Jersey.

Resolution #5

Introduced by: **Union County Medical Society**
Subject: **Blue Shield Participating Physician Agreements**
Referred to: **Reference Committee "C"**

Whereas, fixed fee Blue Shield programs preclude participating physicians from access to any major medical insurance carried by service benefit subscribers; and

Whereas, a nonparticipating physician is able to collect the balance of his bill from any such major medical insurance up to the full limits of the policy; and

Whereas, such a contract stipulation in the fixed fee programs is discriminatory against participating physicians; and

Whereas, patients receive such major medical coverage as part of a benefit package in lieu of a portion of salary yet derive diminished monetary benefit therefrom; now therefore be it

Resolved, that the House of Delegates of the Medical Society of New Jersey demand that Blue Shield *and all major medical carriers* permit access by both participating and nonparticipating physicians to any major medical coverage sold as part of a benefits package; and be it further

Resolved, that if Blue Shield *and all major medical carriers* ignore the legitimate demand of this House of Delegates such legal action be taken as deemed appropriate by the Board of Trustees to carry out the wishes of the House.

Resolutions #5, #6, and #9 were considered together by the Reference Committee. The resolutions engendered much heated discussion and debate at the meeting of the Reference Committee. The Committee feels the concept of these resolutions has a great deal of merit, but does not feel the resolutions can be adopted as written.

The Reference Committee **recommends** that Resolution #5 be referred to the Board of Trustees.

HOUSE ACTION: Adopted as amended. (Italics indicate changes.)

RESOLUTION #6

Introduced by: **Union County Medical Society**
Subject: **Verifying Eligibility for Service Benefits**
Referred to: **Reference Committee "C"**

Whereas, fixed fee Blue Shield programs offer coverage to service benefits subscribers who ostensibly fall below the income requirement for said benefits; and

Whereas, Blue Shield does not verify income at the time the subscriber joins the plan nor on an annual basis thereafter, but accepts a simple statement from the patient that he is eligible without any further verification except an occasional random telephone "audit" to an occasional subscriber; and

Whereas, verification of income is left to the participating physician with a consequent deterioration of the doctor-patient relationship; now therefore be it

Resolved, that the House of Delegates of the Medical Society of New Jersey demand that Blue Shield, as purveyors of the program, assume full responsibility for verifying eligibility for service benefits on an annual basis and for providing proof of such eligibility to th physician; and be it further

Resolved, that if Blue Shield refuses to accept it responsibility in this matter, such legal action be take as deemed appropriate by the Board of Trustees of th Medical Society of New Jersey to carry out the wishe of the House.

Resolutions #5, #6, and #9 were considered togethe by the Reference Committee. The resolution engendered much heated discussion and debate at th meeting of the Reference Committee. The Committe feels the concept of the resolutions has a great deal c merit, but does not feel the resolutions can be adopte as written.

The Reference Committee **recommends** that Resc lution #6 be referred to the Board of Trustees.

HOUSE ACTION: Adopted.

RESOLUTION #9

Introduced by: **Robert J. Weierman, M.D., Delegate, Essex County**
Subject: **Prevention of Windfall Profits**
Referred to: **Reference Committee "C"**

Whereas, a number of insuring entities are using a service benefit format that produces a lower payment when services are provided by a nonparticipating physician; and

Whereas, this method of operation produces a windfall profit to the insurance carrier when a nonparticipating physician is selected by the insured patient; now therefore be it

Resolved, that the Medical Society of New Jersey seek the passage of legislation that requires carriers that pay a lower fee, when a nonparticipating physician renders a service, to pay a premium rebate or dividend to the insured patient.

Resolutions #5, #6, and #9 were considered togethe by the Reference Committee. The resolutions engendered much heated discussion and debate at the meeting of the Reference Committee. The Committee feels the concept of these resolutions has a great dea of merit, but does not feel the resolutions can be adopted as written.

The Reference Committee **recommends** that Reso lution #9 be referred to the Board of Trustees.

HOUSE ACTION: Referred to the Board of Trustees.

RESOLUTION #16

Introduced by: **Mercer County Medical Society**
Subject: **Opposition to Mandatory Assignment Under Medicare**
Referred to: **Reference Committee "C"**

Whereas, since the inception of Medicare, it has been the physician's prerogative to accept or to decline assignment for payment of medical services; and

Whereas, recently Congress has attempted to mandate acceptance of assignment as a condition of hospital staff appointment; and

Whereas, hospital staff privileges requiring assignment acceptance is a discriminatory and unjustified form of fee control—forcing the physician into an untenable position to the detriment of his patients; now therefore be it

Resolved, that the Medical Society of New Jersey request the American Medical Association *continue* to oppose vigorously any attempt by Congress to direct

n any fashion mandatory assignment under Medicare.

The Reference Committee **recommends** the adoption of Resolution #16 with line 13 amended as indicated by italics.

HOUSE ACTION: Adopted as amended by the Reference Committee.

RESOLUTION #17

ntroduced by: **Essex County Medical Society**
Subject: **Legal Service Evaluation**
Referred to: **Reference Committee "C"**

Whereas, the Medical Society of New Jersey has recommended and endorsed for the membership of the Medical Society of New Jersey a specific legal services plan administered by a specific attorney's office, to provide certain legal services to the members of said plan should a problem be incurred with the State Board of Medical Examiners; and

Whereas, as a result of such recommendation and endorsement, many members of the Medical Society of New Jersey are paying an annual fee to said law firm; and

Whereas, the membership of the Medical Society of New Jersey has not received a report or other information from Medical Society of New Jersey members of such plan concerning the services provided, charges for services not covered by an annual fee, the number of members who have joined the plan, and such other relevant information; and

Whereas, an increasing number of questions have been raised by the members of the Medical Society of New Jersey concerning the endorsement and recommendation of a particular legal services plan; now therefore be it

Resolved, that the Board of Trustes of the Medical Society of New Jersey forthwith appoint a committee, comprised of members of the Board of Trustees, to conduct a review and evaluation of said endorsed and recommended legal services plan, and report to the Board of Trustees and the House of Delegates of the Medical Society of New Jersey.

The Reference Committee does not believe that Resolution #17 is necessary, since the intent of the Resolution already has been accomplished through the report of the Committee on Medical Defense and Insurance.

The Reference Committee **recommends** that Resolution #17 be rejected.

HOUSE ACTION: Rejected in accordance with the recommendation of the Reference Committee.

RESOLUTION #20

Introduced by: **Charles Harris, M.D., Delegate, Ocean County**
Subject: **Generic Prescriptions**
Referred to: **Reference Committee "C"**

Whereas, physicians have no control over patient compliance with prescriptions; and

Whereas, pharmacists only fill prescriptions specifically as written by physicians in certain limited instances; and

Whereas, pharmacists treat telephoned prescriptions as generic prescriptions because there is no written record; and

Whereas, physicians are responsible legally for the result of generic prescriptions; now therefore be it

Resolved, that the Medical Society of New Jersey petition the legislature to establish that a prescription by a physician is simply his best advice as to medication.

The Reference Committee noted that no one spoke in favor of Resolution #20. The need for the Resolution was not clear to the Committee.

The Reference Committee **recommends** that Resolution #20 be rejected.

HOUSE ACTION: Rejected in accordance with the recommendation of the Reference Committee.

RESOLUTION #23

Introduced by: **Charles Harris, M.D., Delegate, Ocean County**
Subject: **Nursing Care**
Referred to: **Reference Committee "C"**

Whereas, state regulations determine when hospitals have an adequate nursing staff; and

Whereas, the regulations do not take into account the time spent on administrative and nonclinical duties; now therefore be it

Resolved, that the Departmnt of Health remove administrative hours from its calculations when determining the adequacy of nursing staffs; and be it further

Resolved, that the Department of Health be requested to examine whether this paperwork could be performed by clerks supervised by a nurse.

The Reference Committee noted that no one spoke in favor of Resolution #23. The need for the resolution was not clear to the Committee.

The Reference Committee **recommends** that Resolution #23 be rejected.

HOUSE ACTION: Adopted. Rejection of Resolution #23 by Reference Committee was overridden.

RESOLUTION #24

Introduced by: **Charles Harris, M.D., Delegate, Ocean County**
Subject: **Mandatory Assignment**
Referred to: **Reference Committee "C"**

Whereas, the United States Congress is considering legislation to mandate physician acceptance of assignments as payment in full; and

Whereas, these proposals also require physicians to accept assignments in order to maintain hospital privileges; now therefore be it

Resolved, that the Medical Society of New Jersey *urge the American Medical Association to* research the constitutionality ~~of the concept~~ of mandatory assignment being proposed by Congress or any other proposal to force physicians to accept prestipulated fees.

The Reference Committee **recommends** the adoption of Resolution #24 amended, as indicated by italics.

HOUSE ACTION: Adopted as amended by the Reference Committee.

RESOLUTION #25

Introduced by: **Middlesex County Medical Society**
Subject: **Collective-Bargaining Agent for Physicians' Services**
Referred to: **Reference Committee "C"**

Whereas, the ability of the American physician to maintain high standards through self-regulation has been eroded by various legislative acts; and

Whereas, professional standards are supervised and regulated by government agencies, sometimes without the right of appeal; and

Whereas, fee schedules are set by the business community, by government, and by other third-party groups without input from the organized medical societies, frequently because these societies are prevented, by law, from dealing with matters relating to fees, etc.; now therefore be it

Resolved, that the Medical Society of New Jersey develop a contingency plan to enable the Society, or an organization it sponsors, to act as a collective-bargaining agent for its members; and be it further

Resolved, that the Medical Society of New Jersey report these plans at the next special or regular meeting of its House of Delegates; and be it further

Resolved, that the American Medical Association be asked to develop similar plans in a similar time frame.

The Reference Committee **recommends** that Resolution #25 be adopted.

HOUSE ACTION: Adopted.

Reference Committee "D"

Reports:

COUNCIL ON LEGISLATION
COUNCIL ON PUBLIC RELATIONS
BOARD OF TRUSTEES' ITEMS
RESOLUTIONS #8, #14, #15, #26, #29E

Members:

Peter Amirata, Jr., M.D., Chairman, Essex
Charles Harris, M.D., Ocean
Peter A. Mele, M.D., Bergen
Carl Restivo, Jr., M.D., Hudson
Frank R. Romano, M.D., Union
Catherine E. Spears, M.D., Alternate Member, Morris

Council On Legislation

Irving P. Ratner, M.D., Chairman, Willingboro
(Reference Committee "D")

This report presents a summary of the ultimate status of legislative measures of primary concern during the First Annual Session of the 200th Legislature. The Council's operations, together with a cumulative report of MSNJ's official positions on current legislation, are reflected regularly in the official bulletins dispatched to state legislative keymen and to component societies, and in items published in the *Membership Newsletter* and *The Journal.*

The Council on Legislation continues its established policy of inviting an official representative from each specialty society to all Council meetings. A notice announcing the date of each of the Council's meetings also is sent to all MSNJ official intermediaries with New Jersey specialty societies.

The Council urges that more representatives attend its meetings so that it may have the benefit of the timely thinking of specialty societies concerning proposed legislation affecting the specialty fields.

The Council on Legislation agreed, in order to fortify our stand on legislative bills and make our position known throughout the Society, that it be a standing policy to invite the chairman of each Council and Standing Committee to attend the legislative meetings and to give them the right, if they cannot attend, to select a representative. A Bylaw amendment makes it possible for one Auxiliary member to be appointed, by the President, to serve on the administrative councils and committees for a one-year term to be a full voting member of the respective council and/or committee.

Of the bills reported to the House from the Second Session of the 200th Legislature the following were signed into law:

APPROVED

S-227 —Establishes an Advisory Council, within the Department of Health, to advise the Director of the Division of Narcotic & Drug Abuse concerning the preparation and implementation of an annual drug abuse prevention and treatment plan for New Jersey. The 17-member Council would consist of 9 citizen members appointed by the Governor and 8 ex-officio members.

S-524 —Extends governmental immunities to private physicians performing services for public entities whether as volunteers or independent contractors.

S-1115 —Permits physical therapy services to be ordered by dentists within the scope of their licensed practice.

S-1454 —Requires the Department of Health to prepare posters and pamphlets on choke prevention techniques which then must be displayed prominently in restaurants.

S-1754 —Authorizes the Director of the Division of Motor Vehicles to expand the current driver's license examination by 20 percent to cover the subject of alcohol or drugs as related to highway safety.

A-2057 —Creates a separate licensing board for physical therapists and deletes the necessity of referral or direction from a fully licensed physician. (Bill amended to meet MSNJ's objections.)

ACTIVE SUPPORT

A-1055 —Allows schools of professional nursing to receive pro rata capitation for part-time students.

DISAPPROVED

A-1719 —Provides that any person who presents an oral or written statement in support of a claim for payment of benefits under an insurance policy which contains any false, incomplete, or misleading information, could be charged with a violation. This would be directed against both individuals and practitioners of the healing arts. (MSNJ's comments on interpretation were added to the bill and accepted by the Governor's Council.)

ACTIVE OPPOSITION

S-967 —Creates a direct licensing system within the Division of Consumer Affairs for speech therapists and audiologists. Continuing education is mandated. The individuals so licensed would function independently. (Some MSNJ amendments were incorporated.)

S-1813 —Provides that registered nurses may make determinations and pronouncements of death and officially attest and execute the certificate of death. (Bill amended to meet MSNJ's objections.)

A-784 —This bill requires: (a) A health care facility to report to the State Board of Medical Examiners (hereinafter referred to as the Board) any disciplinary proceedings or action taken by the governing board

of a facility against a board licensed physician or surgeon, or any malpractice insurance settlement, judgment, or arbitration award to which the facility is a party. (b) An insurer or insurance association to immediately notify the Board, in writing, of any medical malpractice, claim settlement, judgment, or arbitration award over $25,000, against any board licensed physician or surgeon insured by the insurer or association.

The following bills of medical interest were introduced into the 1983 Legislature and signed into law, but too late to be reported to the 1983 House of Delegates.

S-3556 —To add "biochemical genetics" to the list eligible for a bioanalytical laboratory director's specialty license.

A-3643 —To appropriate $530,000 to the Department of Health for support of immunology laboratory joint research into the problem of acquired immunodeficiency syndrome (AIDS).

A-3881 —To provide that no autopsy or dissection may be permitted if a surviving relative or friend of the deceased objects to the procedure on the grounds that it was contrary to the deceased's religious beliefs.

A-3981 —The New Jersey Automobile Insurance Freedom of Choice and Cost Containment Act of 1984.

ACR-3011 —Memorializes Congress to repeal certain changes in the Medicare Law.

RESOLUTION #2 (1983 HOUSE OF DELEGATES): LEGISLATION TO REQUIRE THE ATTORNEY GENERAL TO SEPARATE THE ROLES AND FUNCTIONS OF PROSECUTORS AND ADVISORS TO THE STATE BOARD.

Legislation was introduced last year **(A-719)**, but did not move and died at the end of the 1982 to 1983 Legislative Session. **A-780** which established an independent executive branch review of every proposed administrative rule was introduced into the 1984 to 1985 session and is supported by the Governor's Commission to study the Office of Administrative Law **(SCR-070)** concerning Resolution #2. The Governor's Commission, chaired by former State Senator Frank McDermott, recommended legislation that would make the decision of Administrative Law Judges final with appeals going directly to the courts.

The Council on Legislation, MSNJ lobbyists, and MSNJ staff spent the latter part of the 1983 legislative year opposing bills to pass laws that would expand the practice and privileges of ancillary groups at the expense of the physicians plus a bill that would allow optometrists to prescribe drugs **(A-2149)**.

A very difficult situation is presented by no-fault and the position of the auto insurance companies and the State Department of Insurance. Both are pressing for a law which would reimburse physicians at less than their usual and customary fees for treating patients injured in auto accidents.

At this point more than 100 bills of medical interest have been introduced since January and you will see on the forthcoming Legislative Supplemental Report that the 1984 to 1985 legislative year promises to be one of great importance to physicians in New Jersey.

FEDERAL LEGISLATION

Federal Trade Commission—The AMA and the FTC have moved forward on most of the vexing issues and it seems as if the matters of dispute have been fairly resolved.

Medicare—Mandatory assignments were defeated late in 1983. The Chairman of the House Ways and Means Committee still is an advocate of that concept and has reintroduced the legislation. It has not shown significant support at present. The AMA expects it to be an issue through most of this decade.

DRG—A fact of life for the rest of the country. They also are being considered for physician reimbursement. The AMA is opposing their extension to physicians.

Tax Equity and Fiscal Responsibility Amendments of 1982—Received a great deal of publicity. Their main thrust is a distinction between a Part A-Part B service. The present federal waiver in New Jersey has temporarily suspended TEFRA. It will be implemented in the future. Hospital-based physicians carefully should analyze its impact on their practice and be prepared to insulate themselves where necessary to maximize potential benefits.

The Reference Committee **recommends** that the report be filed.

HOUSE ACTION: Filed.

Supplemental Report #1: Council on Legislation

(Reference Committee "D")

CURRENT STATE LEGISLATION

The Council considered a list of bills of medical import and recommended the positions indicated. Asterisk denotes bills of medical significance.

S-3 Laskin—Criminal Responsibility
Would abolish the defense of insanity, but would allow evidence of mental condition to be considered at the time of sentencing. **ACTION DEFERRED,** pending further information from the Council on Mental Health.

S-46 Weiss—Drug Treatment Facilities
Would preclude the issuance of a certificate of need for a drug treatment facility in a municipality of less than 25,000 persons unless the facility is used solely for the needs of that municipality. **NO ACTION.**

S-59 Codey—Catastrophic Health Insurance
Creates a catastrophic health insurance fund to reimburse individuals for catastrophic costs incurred because of injury or illness. The fund is to be capitalized initially by the state which then would bill private carriers for their insureds. The carriers then would be permitted to recapture losses by plac-

ing surcharges on their policies. The mechanism is to be monitored by the Insurance Department and administered via a "New Jersey Catastrophic Health Insurance Underwriting Association." **DISAPPROVED,** although MSNJ approves the concept of catastrophic health insurance, this bill would change the insurance companies into fiscal intermediaries, is not sound fiscally, and would prove counterproductive.

S-61 Cody—Medicaid
Permits hospitals to contract with Medicaid to operate long-term care units created by designating their underutilized acute care beds for that purpose. The contract expires on December 31, 1985, and the beds revert to acute status. **DISAPPROVED,** because this bill would cause confusing alterations of hospital status.

S-70 Codey—Commissioner of Health*
Removes the requirement that the State Commissioner of Health shall be a duly licensed physician. **ACTIVE OPPOSITION,** because the health care needs of our population require that a licensed physician serve in the position of Commissioner of Health. There are many qualified candidates. It is not advisable to dilute the requirements.

S-83 Bubba—Patient Rights
Would establish a bill of rights for hospital patients. The rights enumerated are essentially the developed common-law rights of patients in this state. The hospital administrator must supply written notice of these rights to all patients and post the notice in a conspicuous public place in the facility. **APPROVED.**

S-89 Bubba—Criminal Responsibility
Abolishes the defense of insanity in criminal cases. **ACTION DEFERRED,** pending further information from the Council on Mental Health.

S-111 Bubba—Surgical Consent Forms*
Requires physicians personally to present and obtain surgical consent forms and signatures. The form shall state the name of any assisting physician that performs surgery under the supervision of the attending. **ACTIVE OPPOSITION,** this procedure relates to physician/patient relationship. It should not be a matter of licensure law. It is well addressed in civil and regulatory law.

S-139 Rand—Cancer Research
Adds two members to the Commission on Cancer Research. **NO ACTION.**

S-140 Rand—Anatomical Gift
The purpose of this bill is to require hospitals to ascertain, upon admission, whether patients have made an anatomical gift and to whom the gift was made. A hospital is required to maintain this information as part of a patient's permanent record, which will facilitate the discharge of the patient's wishes. **NO ACTION.**

S-153 Foran—Products Liability
Provides a six-year statute of limitations in products liability actions. Establishes rebuttable presumptions that products are free of defects. **NO ACTION.**

S-226 O'Connor—Care of Newborns (A-1184)*
Requires hospitals to adopt policies and procedures which ensure newborns receive nourishment and care consistent with accepted medical standards. **ACTION DEFERRED,** pending further information from the New Jersey Chapter, American Academy of Pediatrics.

S-243 Hagedorn—Involuntary Commitments*
Restructures existing laws to provide that: 1. The Board of Freeholders shall designate one or more screening centers within their counties or on an intercounty basis as the Department of Human Services may approve. 2. The screening service shall provide examinations, diagnoses, evaluation, and emergency treatment in accordance with departmental regulations. 3. Involuntary commitments are to be certified to by two psychiatrists, or one psychiatrist and one licensed physician, or a psychiatrist and a psychologist. 4. The screening or commitment process is to be initiated by a sworn document signed by an immediate family member, next-of-kin, physicians, psychiatrist, county medical examiner, social worker, police official, county prosecutor, or a county or municipal welfare director. 5. Screening services shall hold persons determined to be dangerous for no more then 72 hours before the involuntary commitment mechanism must be complied with. 6. Patients being admitted to screening centers or institutions have a detailed list of rights including the immediate right to counsel. **ACTIVE OPPOSITION,** because this legislation would not improve the present mechanism and by creating another level of service would tend to increase mental health delivery costs in New Jersey.

S-272 Hagedorn—Nursing Education
Prohibits the Board of Nursing from closing a particular class or type of professional nursing school. **APPROVED.**

S-317 Lynch—Contact Lenses*
Creates the profession of contact lens dispensing and fitting for nonphysicians and nonoptometrists. Licensure and regulation would be through the Board of Examiners of Ophthalmic Dispensers and Ophthalmic Technicians. A prescription by a licensed optometrist or physician would be required. **ACTIVE OPPOSITION,** to that portion of the bill referring to the fitting of contact lenses, because MSNJ does not feel it would be beneficial to the health of the consumer. Contact lenses improperly used or fitted may cause irreparable damage to the cornea. The fitting of contact lenses should be done by the prescribing ophthalmologist or optometrist.

S-331 Lynch—Medicaid
Requires Medicaid to provide treatment for patients that are drug abusers. The treatment must be prescribed by a physician and provided in an approved facility. **ACTION DEFERRED,** pending further information from the Committee on Drug and Alcohol Abuse.

S-370 Connors—Childbirth
Requires hospitals to allow fathers to observe deliveries as long as the mother and the attending physician or midwife agree. **NO ACTION.**

S-373 Connors—Review of Administrative Rules*
Creates a legislative commission to review rule proposals for the purpose of determining whether they are adequate, appropriate, equitable, necessary, reasonable, understandable, consistent with legislative intent, and within statutory authority and case law. **APPROVED.**

S-424 Dorsey—Professional Boards*
Creates a "sunset" law for state agencies. The State Board of Medical Examiners would terminate within five years unless it could demonstrate a public need for its continued existence. The review would be conducted by the Joint Committee on Regulatory Agencies. **ACTIVE SUPPORT.**

S-425 Dorsey—Corporations
The bill affects corporations whose stock is not traded over-the-counter or on the exchanges. It provides that the ten largest shareholders and the directors and officers are liable for unpaid wages and other compensation if they cannot be collected from the corporation. **NO ACTION.**

S-441 Dorsey—Renal Disease Treatment Centers
Provides state support of renal disease treatment centers operated by private, nonprofit agencies if they have been approved by the state. **NO ACTION.**

S-442 Dorsey—Physical and Psychiatric Examinations
Permits Boards of Education to require employees to pass physical and mental examinations to determine their suitability for employment. **APPROVED.**

S-459 Dorsey—Protective Packaging
Requires that over-the-counter drugs or dietary supple-

ments be packaged in tamper-proof containers. **APPROVED.**

S-465 Dorsey—Immunity for Specimen Collection and Analysis*

Provides immunity for health personnel who have taken and analyzed samples of breath, blood, urine, or other bodily substances at the request of law enforcement authorities. A certificate by the individual giving the details of the test would be admissable in evidence. Thus, health care personnel would not be required to appear in court. **APPROVED.**

S-481 DiFrancesco—Surrogate Parenthood

Provides for the arrangement of surrogate parenthood contracts. Following agreement to the contract a petition is filed in the Superior Court. An investigation will be conducted. If all requirements are met the Court will approve the petition if the investigating agency so recommends. **NO ACTION.**

S-487 DiFrancesco—Catastrophic Illness in Children Relief Fund

Establishes the Catastrophic Illness in Children Relief Fund and the Catastrophic Illness in Children Relief Fund Commission, in but not of, the State Department of Health. The fund shall be administered by the Commission and credited with monies from certain surcharges by insureds of health insurance collected under this bill. Providers of health insurance shall collect from insureds a surcharge upon the premium paid for their health insurance policies. The amount of the surcharge shall be paid over to the state treasurer for deposit in the fund. The amount of the surcharge shall not exceed 5 percent of the premium paid on a health insurance policy. Subject to certain rules and regulations established by the commission, children, through their parents or legal guardians, are eligible for financial assistance from the fund if they are residents of this state and have a catastrophic illness. A catastrophic illness is any illness except for a mental illness or developmental disability, the medical expenses whereof are not covered by any other assistance or insurance and exceed 30 percent of the gross income of a family whose gross income is $100,000 or less per year or 40 percent of the gross income of a family whose gross income is over $100,000 per year. **ACTION DEFERRED,** pending futher information from the New Jersey Chapter, American Academy of Pediatrics.

S-504 Lesniak—Criminal Responsibility

Provides for a determination of guilty, but mentally ill, when a defendant has pleaded a defense of insanity if, a) the defendant is found guilty, b) he was not legally insane at the time of the crime, and c) was mentally ill or mentally retarded as defined in N.J.S.A. 30:4-23 at the time of commission of the crime. **ACTION DEFERRED,** pending further information from the Council on Mental Health.

S-510 Lesniak—Workmen's Compensation*

This bill would provide that employed physicians treating fellow employees would be liable for negligent acts. **DISAPPROVED,** this legislation is unnecessary and duplicative. There already is a process available for such claims through the workmen's compensation statutes.

S-515 Lesniak—Limited X-ray Technologist*

Provides for the certification of limited x-ray technologists in the areas of podiatry, orthopaedics, and urology. ~~**ACTIVE OPPOSITION,**~~ this bill would lower the standards which currently assure the public of safe levels of radiation when undergoing diagnostic x-rays. **NO ACTION.**

S-535 Dumont—School Psychologists*

Would allow school psychologists to practice "school psychology" privately, outside their school district, without the necessity of a license to practice clinical psychology. **DISAPPROVED,** because it would be unsound to allow an unlicensed psychologist to perform psychotherapy.

S-560 Lipman—Health Insurance

Requires health insurers to provide second opinion coverage for pregnancy-related surgery and sterilization procedures. Also, requires maternity coverage be offered on the same basis as all illness protection. **NO ACTION.**

S-561 Lipman—Health Insurance

Same as **S-560. NO ACTION.**

S-562 Lipman—Health Insurance

Same as **S-560** and **S-561. NO ACTION.**

S-563 Lipman—Health Insurance

Same as **S-560, S-561,** and **S-562. NO ACTION.**

S-600 Lesniak—Campaign Contributions

Requires that the name of the employer of any person who contributes over $100 shall be reported to the Election Law Enforcement Commission. **DISAPPROVED,** this bill would be an infringement on an individual's privacy and create an impossible reporting system.

S-607 Bassano—School Buses

Requires that all metal seat backs and bars on school buses be padded. **ACTIVE SUPPORT.**

S-629 Bassano—Immuno-Augmentative Therapy (I.A.T.)*

Permits the use of I.A.T. when prescribed by a licensed physician. No institution may prohibit its use. A statutory form of informed (consent) request is established and must be filed with the institution and the Department of Health. The Commissioner of Health is to report to the Governor annually about the number of cases and their status. **ACTION DEFERRED,** pending further information from the New Jersey Oncology Society, MSNJ's Committee on Cancer Control, and further clarification/literature from the sponsor of the bill.

S-711 Saxton—Certificate of Need/Nursing Homes

Allows nursing homes to automatically add three beds within any given five-year period. **NO ACTION.**

S-723 Brown—Breast Cancer*

Requires the Department of Health to prepare a booklet on breast cancer which must be given to breast cancer patients by their physicians. **ACTIVE OPPOSITION,** because specific acts of medical judgment and patient information should not be legislated, but must be developed by science, education, and standards of practice.

S-752 Hirkala—Confidentiality

Extends confidentiality to data in the possession of hospital peer review committees. **ACTIVE SUPPORT.**

S-754 Hirkala—Civil Immunity of Review Committees*

Extends civil immunity to hospital board members when exercising good faith in considering the appointment or dismissal of medical staff applicants. **ACTIVE SUPPORT.**

S-760 Hirkala—Medicaid Coverage

Creates a commission to determine whether it is feasible to provide Medicaid coverage to handicapped children. **ACTION DEFERRED,** pending further information from the New Jersey Chapter, American Academy of Pediatrics.

S-828 Orechio—Mobile Intensive Care

Provides that Medicare eligible recipients of MICU services shall not be required to pay for those services. Any gap in Medicare coverage is to be made up by Medicaid. **NO ACTION.**

S-875 Hurley—Withholding or Withdrawing of Services in the Event of Terminal Illness

Empowers adults to execute a statutory form of directive to their physicians providing for the withholding or withdrawing of life-sustaining procedures during a terminal illness. The directive would be valid for five years and provides immunity for physicians and other providers complying with such a directive. "Life sustaining" means a modality or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function which would serve only artifically to prolong the moment of death where in the judgment of the attending physician death is immi-

nent whether or not such procedures are utilized. It does not include "the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain." **NO ACTION,** refer to MSNJ's Committee on Biomedical Ethics.

S-911 Russo—Terminal Illness
Amends the Juvenile Terminal Illness Assistance Act to include adults. **APPROVED.**

S-913 Russo—Good Samaritan Act
Clarifies the Good Samaritan Act to include all emergency situations regardless of location. **APPROVED.**

S-924 Russo—Educational and Health Facilities
Excludes educational facilities and hospitals from the Coastal Area Facility Review Act. **ACTION DEFERRED,** pending further information on this bill from its sponsor.

S-935 Russo—Discontinuance of Medical Treatment
Provides that any person of sound mind and 18 years old may execute a declaration directing the withholding or withdrawing of life-sustaining procedures in a terminal condition. The declaration is to be filed with an agency. (That agency is not identified in the bill.) **NO ACTION,** refer to MSNJ's Committee on Biomedical Ethics.

S-989 Dalton—Mobile Intensive Care Unit (MICU)*
Allows mobile intensive care nurses and paramedics to perform Advance Life Support Systems (ALSS) authorized by the Commissioner when direct voice communications are received from a physician or physician-directed nurses. In the event of a loss of communications, action can be instituted by the MICU personnel. **APPROVED.**

S-1010 Feldman—Professional Liability*
Would require plaintiffs in medical malpractiee suits to file an affidavit of a practicing physician indicating there is a reasonable probability that a deviation from accepted standards occurred. The affidavit is not required if the defendent failed to provide plaintiff with medical records on a timely basis. The affidavit is waived if there is not sufficient time to file within the statute of limitations. The judge, in his/her discretion may, on motion, grant a summary dismissal. MSNJ will seek amendment on line #13 to change "board licensure" to "specialty board certification." **NO ACTION,** in favor of **S-1140.**

S-1016 Feldman—Privileged Communications*
Extends priviledged communications to psychiatric social workers and nurses. It also, by implication, advances the concept that persons other than physicians and psychologists may treat mental health conditions. **DISAPPROVED,** unnecessary legislation—individuals being directed and employed by physicians or psychologists are covered by that privilege.

S-1017 Feldman—Confidentiality of Medical Claims Information
Provides that employers could not review medical claims submitted by employees on claims through the employers' coverage. It assumes that employers discourage claims in order to contain premiums. Applies to Blue Cross. **APPROVED,** request sponsor to include temporary disability forms in this bill.

S-1018 Feldman—Confidentiality of Medical Claims Information
Same as **S-1017** except it applies to group health insurers. **APPROVED,** request sponsor to include temporary disability forms in this bill.

S-1019 Feldman—Confidentiality of Medical Claims Information
Same as **S-1017** except it applies to medical service corporations. **APPROVED,** request sponsor to include temporary disability forms in this bill.

S-1050 Russo—Determination of Death*
Defines death to include cessation of brain function. No action could be taken, however, in reliance on that fact if it would violate the bona fide religious beliefs of the individual as attested to by a family member or next of kin. **CONDITIONAL APPROVAL,** pending removal of religious preference language from the bill.

S-1056 Hurley—Motor Vehicles
Extends implied consent to the taking of blood and urine testing to determine if a driver is "under the influence." Penalties for refusal by repeat violators correspond to penalties for repeat drunken driving. **APPROVED.**

S-1067 Feldman—Social Work*
This bill would establish and license two categories of social workers and would create a Board of Social Work Examiners in the Department of Law and Public Safety whose powers and duties, among others, would be to administer the act, examine and license candidates for the various categories of social work, and promulgate rules and regulations necessary for the effective enforcement of the act. The two categories of licensed social work would be (1) social work specialists, who would be required to have a doctorate in social work or a master's degree from an accredited school of social work and (2) social workers who would need a baccalaureate degree from an accredited college or university social work or social welfare program. The bill would "grandfather" in all persons currently in practice, provided they have been in practice in one of the two licensed categories for two of the last five years and apply to be licensed within 180 days from the effective date of this act. **ACTIVE OPPOSITION,** because there has been no demonstrative need for this type of licensure.

S-1071 Bassano—Mental Health Records
Requires institutions to make available mental health records upon request when the patient is an applicant for a police position or firearm permits. **DISAPPROVED,** unnecessary legislation.

S-1079 Dumont—Statute of Limitations*
Provides for a three-year statute of limitations, except for fraud, intentional concealment, or nontherapeutic or diagnostic purpose. Minors would have until age 11 or any injury prior to age 8. **ACTIVE SUPPORT.**

S-1083 Cardinale—Protective Services for Adults
Requires the reporting of vulnerable adult abuse to county agencies which would then investigate and institute protective services. **APPROVED.**

S-1099 Bassano—Nursing Home Beds
Requires nursing homes to hold a bed for 14 days for Medicaid patients transferred to acute care facilities. The nursing home will be reimbursed by Medicaid during that time. **APPROVED.**

S-1112 Hurley—Cap on Damages
Provides a $100,000 cap on damages for pain and suffering to personal injury actions. **ACTIVE SUPPORT.**

S-1122 Saxton—No-Fault
Provides that tort litigation may be brought following an auto accident when there is an injury which results in death, serious impairment of body function, or permanent serious disfigurement. **APPROVED.**

S-1127 Costa—Immuno-Augmentative Therapy (I.A.T.) (S-629)*
Permits the use of I.A.T. when prescribed by a licensed physician. No institution may prohibit its use. A statutory form of informed (consent) request is established and must be filed with the institution and the Department of Health. The Commissioner of Health is to report to the Governor annually about the number of cases and their status. **ACTION DEFERRED,** pending further information from the New Jersey Oncology Society, MSNJ's Committee on Cancer Control, and further clarification/literature from the sponsor of the bill.

S-1135 Dalton—Damages in Personal Injury and Wrongful Death*
Provides that collateral sources of payment shall be used to offset damages. Further provides for structural payments may be used at the request of either party if the future damages exceed $100,000. **ACTIVE SUPPORT.**

S-1140 Feldman—Professional Liability*
Provides that within ten days of filing an action against a physician the plaintiff must provide an affidavit from an expert that there has been a negligent deviation from the accepted standards of practice. **ACTIVE SUPPORT.**

S-1147 Hirkala—Podiatry
Would permit the SBME to waive the internship requirement for podiatrists coming from practice in another state without requiring ten years of experience. **ACTION DEFERRED,** pending further information from the SBME.

S-1148 Orechio—Group Health Insurance Coverage Related to Drug Abuse Treatment
Requires Blue Cross to cover the expense of treatment for drug abuse as for any other illness. **DISAPPROVED,** because this bill does not distinguish between medical-psychiatric treatment and social rehabilitation programs. It does not establish limits of fiscal responsibility. As a consequence, it jeopardizes health care funds which are in short supply.

S-1151 Orechio—Individual Health Insurance Coverage/Drug Abuse Treatment
Same as **S-1148,** but applies to commercial carriers. **DISAPPROVED,** same as **S-1148.**

S-1152 Orechio—Medical Service Corporation Insurance Coverage Related to Drug Abuse Treatment
Same as **S-1151,** but applies to Blue Cross/Blue Shield. **DISAPPROVED,** same as **S-1148** and **S-1151.**

S-1153 Orechio—Group Health Policies (Drug Abuse)
Same as **S-1151,** but applies to group coverage. **DISAPPROVED,** same as **S-1148, S-1151,** and **S-1152.**

S-1154 Orechio—HMO Coverage (Drug Abuse)
Same as **S-1151,** but applies to HMOs. **DISAPPROVED,** same as **S-1148, S-1151, S-1152,** and **S-1153.**

S-1163 Cardinale—Monosodium Glutamate*
Requires restaurants to notify customers if they use monosodium glutamate in the preparation of their food or add it to the food after preparation. Notice would be, in writing, on or attached to the menu. **APPROVED.**

S-1164 Cardinale—Education*
Requires Board of Education to provide examinations for obesity of pupils between the ages of 6 and 18. **DISAPPROVED,** this legislation would allow persons who are not licensed to practice medicine.

S-1182 Saxton—Medical Fees (No-Fault)*
Creates an Insurance Fee Schedule Board which will establish the maximum allowable fees which could be billed to insurance carriers under the no-fault law. **ACTIVE OPPOSITION,** because there are systems under existing law that address this issue. Fees charged by physicians are subject to review by the SBME and enforcement by the Office of the Attorney General. Additionally, physicians may not charge a higher fee in the event of third-party liability. This legislation, therefore, is unnecessary.

S-1190 Feldman—Frivolous Litigation
Authorizes courts to award reasonable attorney's fees to a party who has been subjected to a frivolous claim. **ACTIVE SUPPORT.**

SCR-70 Dalton—Administrative Law
Creates a Commission to study the scope of authority of the Office of Administrative Law. **APPROVED.**

SJR-24 Hirkala—Alcoholism
Requires the Department of Health to conduct a comprehensive study of the effectiveness of existing laws regarding alcoholism and treatment. (The Assembly Judiciary Committee has concluded the Department of Health has not fulfilled the mandates of existing legislation.) **APPROVED.**

The Reference Committee **recommends** the report to be filed.

HOUSE ACTION: Filed, with one change, position on S-515 to read NO ACTION.

Supplemental Report #2: Council on Legislation

(Reference Committee "D")

The Council considered a list of bills of medical import and recommended the positions indicated. Asterick denotes bills of medical significance.

S-925 Russo—Workmen's Compensation (Free Choice of Physician)
Allows injured workers to select, upon notice to their employer, their own physician or hospital for the treatment of covered injuries. **APPROVED.**

S-1044/Hagedorn and S-1100/Bassano—Nursing Homes
Provides that nursing homes may be compensated by Medicaid for reserving beds for ten days for patients who have been transferred to acute care facilities. **APPROVED.**

S-1212 Codey—Controlled Dangerous Substances
Repeals the Department of Health's registry of persons convicted of drug offenses. **NO ACTION.**

S-1235 VanWagner—Wrongful Death
Expands recoverable damages in wrongful death actions to include emotional and social factors along with mental anguish. **DISAPPROVED,** Supreme Court decisions in New Jersey have established a reasonable and workable format for awarding damages in wrongful death actions. This bill would create an unwarranted expansion and escalate the cost of casualty insurance without any benefit to the public.

S-1295 Lynch—Athletic Trainers*
Licenses athletic trainers who must be employees of educational institutions or professional teams. They may apply physical therapy at the direction of licensed physicians in conformity with regulations adopted by the SBME. **DISAPPROVED,** individuals functioning as athletic trainers do not require separate licensure. The team physician can and should be responsible for delegating responsibility to the trainer. Trainers should not engage in therapy nor should we risk having the public confuse them with licensed health professionals.

S-1308 Feldman—Nutrition
Creates a 26-member Commission on Hunger to assess the need for services in New Jersey and how those needs might be met. One member of the Commission would be a physician-expert in nutrition. **NO ACTION.**

S-1349 Lipman—Informed Consent*
Requires written consent for breast biopsy and/or repair. Physicians that do not secure written consent are subject to discipline by the SBME. **ACTIVE OPPOSITION,** physicians have the medical legal obligation to secure informed consent from all their patients regardless of the condition involved. The legislature should not become involved in specific acts of medical judgment and patient information. These must be developed by science, education, and standards of practice. If codification is necessary that is a function of the appropriate regulatory agencies.

S-1410 Lesniak—Drug Abuse
Extends health insurance coverage for treatment of drug abuse in licensed facilities (Blue Shield). **DISAPPROVED,** because this bill does not distinguish between medical-psychiatric treatment and social rehabilitation programs. It does not establish limits of fiscal responsibility. As a consequence, it jeopardizes health care funds which are in short supply.

S-1411 Lesniak—Drug Abuse
Same as **S-1410** (group health). **DISAPPROVED,** same as **S-1410.**

S-1412 Lesniak—Drug Abuse
Same as **S-1410** (Blue Cross). **DISAPPROVED,** same as **S-1410.**

S-1413 Lesniak—Drug Abuse
Same as **S-1410** (commercial carriers). **DISAPPROVED,** same as **S-1410.**

A-27 Gill—Blood Donations*
Makes it a criminal offense for a donor, knowingly infected with a communicable disease, to donate blood. **APPROVED.**

A-99 Perun—Sudden Infant Death Syndrome
Creates a program within the Department of Health to educate the public and health professions about the diagnosis and treatment of SIDS. **APPROVED.**

A-107 Otlowski—Involuntary Commitments
Provides that involuntary commitments shall be effected by the certification of two psychiatrists, or a psychiatrist and a physician or a "screening service." At the screening service, the patient is to be evaluated by staff which shall include two psychiatrists, or a psychiatrist and a physician. There are extensive requirements to be complied with by the screening service or the receiving hospital. **APPROVED.**

A-114 Otlowski—Commitment of Mentally Ill
Provides that mental illness and psychiatrist would be defined as: "Mentally ill and in need of hospitalization" means suffering from mental illness and requiring involuntary commitment because of (1) an attempt or threat to commit suicide or to do bodily harm to oneself as manifested by an attempt, suicidal preoccupation, or significant depression; (2) a homicidal or assaultive preoccupation or the inflicting or threatening of serious property damage; (3) the serious impairment of familial financial stability; or (4) the significant impairment of one's physical or mental health or the inflictions upon oneself of substantial bodily injury, or serious physical or mental disease, from lack of self control or judgment in caring for personal need such as shelter, nutrition, or medical attention. "Psychiatrist" means a licensed physician who is either certified or eligible for certification in psychiatry by the American Board of Neurology and Psychiatry or who is a resident in a program approved for certification. Emergency commitments would be on the basis of a certificate of one physician. Temporary commitments would require the certification of two physicians, one of whom must be a psychiatrist. Indeterminate commitments would be pursuant to court order. Physician certificates must be based upon an examination conducted within 5 days of the request for admission. A minor of 16 years or older may apply for voluntary admission, but cannot be detained in that classification beyond 30 days. Voluntary patients may not receive treatment without their consent unless transferred to involuntary status. **APPROVED.**

A-115 Otlowski—Optometric Use of Medications*
Provides that optometrists may use and prescribe drugs for topical application to the anterior segment of the eye. **ACTIVE OPPOSITION.** Optometrists are not medical doctors and, therefore, should not be given the mandate, via legislation, to administer drugs. If the wrong medication is prescribed, what could appear to be a simple problem could develop into a destructive process of the eye in a very short period of time. The bill is short-sighted in attempting to provide lesser cost care to the general public at the expense of quality. (N.B. Admendments are insignificant and not acceptable.)

A-120 Otlowski—Certificate of Need
Exempts home health agencies from the certificate of need law. **APPROVED.**

A-135 Hendrickson—Motor Vehicle License Plates
Provides for special plates for motor vehicles owned by licensed practical nurses or registered nurses. **NO ACTION.**

A-160 Visotcky—Medicaid
Mandates Medicaid coverage of drug abuse treatment ordered by a physician and rendered in a state-approved facility. **DISAPPROVED,** because this bill does not distinguish between medical-psychiatric treatment and social rehabilitation programs. It does not establish limits of fiscal responsibility. As a consequence, it jeopardizes health care funds which are in short supply.

A-182 Markert—Withholding Medical Services
Provides that adults may issue written directives instructing physicians to withhold or withdraw life-sustaining procedures in the event of a terminal condition or to transfer to an appointed agent the ability to make that decision. **NO ACTION,** refer to Committee on Biomedical Ethics.

A-188 Markert—Catastrophic Illness in Children Relief Fund (S-487)
Establishes the Catastrophic Illness in Children Relief Fund and the Catastrophic Illness in Children Relief Fund Commission, in but not of, the State Department of Health. The fund shall be administered by the commission and credited with monies from certain surcharges by insureds of health insurance collected under this bill. Providers of health insurance shall collect from insureds a surcharge upon the premium paid for their health insurance policies. The amount of the surcharge shall be paid over to the state treasurer for deposit in the fund. The amount of the surcharge shall not exceed 5 percent of the premium paid on a health insurance policy. Subject to certain rules and regulations established by the commission, children, through their parents or legal guardians, are eligible for financial assistance from the fund if they are residents of this state and have a catastrophic illness. A catastrophic illness is any illness except for a mental illness or developmental disability, the medical expenses whereof are not covered by any other assistance or insurance and exceed 30 percent of the gross income of a family whose gross income is $100,000 or less per year or 40% of the gross income of a family whose gross income is over $100,000 per year. **ACTION DEFERRED,** pending further information from the New Jersey Chapter, American Academy of Pediatrics.

A-252 Kern—Medical Records (Health Care Facilities)*
Provides that a medical care facility must allow the patient or his representative an opportunity to review the records without charge. Further provides that governmental agencies may have access to records when their agents are identified and for "emergency official reasons." **DISAPPROVED,** "emergency official reasons" is an obscure and indefinite term which could lead to abuse and invasion of privacy. If

government agents cannot secure the permission of the patients or their families then they should obtain court orders.

A-269 Bryant—Withholding Medical Treatment
Amends Title 26 of the Revised Statutes (Health Code) and establishes a procedure whereby a document, executed in conformity with the will statutes, can be relied upon by physicians to withhold or withdraw artificial life-sustaining treatment. **NO ACTION,** refer to Committee on Biomedical Ethics.

A-286 Schuber—State Athletic Commission
Creates a Medical Advisory Board within the Athletic Commission. The Board would consist of nine physicians appointed by the Governor and would develop standards for the examination of professional boxers and wrestlers. **APPROVED.**

A-321 Perun—AIDS
Requires UMDNJ to establish an AIDS (Acquired Immunodeficiency Syndrome) Task Force Center. Also, requires the Department of Health to educate the public and the health professions about the diagnosis and treatment of AIDS. **NO ACTION.**

A-496 Doyle—Renal Dialysis
Would require Blue Cross and Blue Shield to provide coverage for home renal dialysis services. Bill withdrawn from files.

A-534 Weidel—No-Fault
Provides that tort litigation may be brought following an auto accident when there is an injury which results in death, serious impairment of body function, or permanent serious disfigurement. **APPROVED.**

A-551 Herman—Emergency Medical Services*
Allows mobile intensive care nurses and paramedics to perform advance life-support services as authorized by the Commissioner of Health where direct communication from a physician or a physician-directed nurse is maintained. If communication is lost, provision is made for the nurse or paramedic to provide procedures approved by the Commissioner of Health. **APPROVED.**

A-612 Deverin—Abortions
Would permit hospital governing boards to determine whether or not abortions can be performed in the hospital facilities. **ACTION DEFERRED,** pending further information from the New Jersey Hospital Association.

A-620 Deverin—Respiratory Therapists*
Licenses and regulates respiratory therapists to function under the direction or supervision of a licensed physician. The State Board of Medical Examiners would be the licensing agency. **APPROVED.**

A-629 Doria—Nursing Education
This bill would preclude the Board of Nursing from promulgating any regulation that would have the effect of closing a particular type of nursing school. **APPROVED.**

A-643 Haines—Criminal Responsibility
Abolishes the defense of insanity, but allows the illness to be considered as a factor in sentencing. **ACTION DEFERRED,** pending further information from the Council on Mental Health.

A-708 Harwick—Diagnosis Related Group System (DRGs)
Creates a committee to study the DRG program and determine whether it ought to be continued. **ACTIVE SUPPORT.**

A-721 Bennett—CPR
Requires CPR training for high school students. Exemptions would be granted on the basis of violation of religious beliefs. **CONDITIONAL APPROVAL,** pending specific amendments to the bill.

A-760 Cooper—Autopsy Report
Requires medical examiners to supply autopsy results to certain survivors of the decedent within 45 days of receipt of a request from those persons. **NO ACTION.**

A-810 Deverin—Occupational Therapy*
Creates a new class of licensed practitioners who would function independently and would be permitted to perform such services as the design, fabrication, and application of splints, sensorimotor activities, the use of specifically designed crafts, guidance in the selection and use of adaptive equipment, therapeutic activities to enhance functional performance; prevocational evaluation and training, and consultation concerning the adoption of physical environments for the handicapped. The State Board of Medical Examiners will exercise jurisdiction. **DISAPPROVED,** because occupational therapy is a valuable and needed service for a significant number of patients. The need for licensing these therapists has not been clearly demonstrated. This bill, however, lacks the assurance of physician evaluation and direction of the need for and scope of occupational therapy.

A-820 Kalik—Medicaid
Prohibits the use of deductibles and copayments by Medicaid unless required by the federal government. **APPROVED.**

A-872 Gallo—Medicaid
The bill prohibits administrators of institutions from requiring Medicaid patients and their families to contract as private pay patients. It also prohibits the leveraging of contributions from the same patients. **DISAPPROVED,** Medicaid payments to hospitals are based on the same rates as those paid by or, on behalf of, all other patients. Medicaid payments to nursing homes are below the rates fairly charged to other patients. Medicaid patients not paying a fair rate, all other patients are charged more. Medicaid patients and families with assets should make a contribution to a fair rate.

A-873 Franks—Medicaid
Prohibits nursing homes from denying admissions to Medicaid recipients if that home has a Medicaid census below state averages. The Commissioner of Human Services can grant exceptions on a specific basis to this requirement. **NO ACTION.**

A-879 Deverin—Boxing
Provides certain safety features at boxing events including the presence of a neurologist and an ophthalmologist. **NO ACTION.**

A-926 Weidel—Medical Fees—No-Fault*
Establishes a fee schedule for treatments required as a result of auto accidents. The schedules could vary by regions. Patients could be billed for the difference between the insurance reimbursement and the doctor's fee. **ACTIVE OPPOSITION,** there are already several statutes and regulations controlling physicians' fees in New Jersey. These mechanisms should be utilized before the fee schedule is considered. There is no evidence that if physicians' fees are removed from auto insurance in its entirety that any favorable effect will be seen on auto insurance rates.

A-932 Kern—Medical Consents*
Sets a statutory order by which a medical consent can be given if an individual is incompetent or an emancipated minor. **APPROVED.**

A-952 Bocchini—Disposal of Needles and Syringes*
Permits needles and syringes to be destroyed by crushing or burning. **APPROVED.**

A-960 Miller—DRGs*
Allows patients or insurors to appeal excessive charges under the DRG program. **ACTIVE SUPPORT.**

A-963 Miller—DRGs*
Terminates the DRG program and requires the Department of Health to develop an alternate system within one year. **ACTIVE SUPPORT.**

A-985 Gill—Medicaid Nursing Home Beds
Provides for payment to a nursing home to reserve a bed for a resident who is a Medicaid recipient and who is discharged temporarily to a general hospital for a period of ten days. These payments shall be made from moneys deposited in the Casino Revenue Fund. Further provides that a temporarily discharged resident who is unable to return to the nursing home before the ten-day period expires shall have priority for the next available bed in the facility. **APPROVED.**

A-1052 Paterniti—Criminal Responsibility
Abolishes insanity as a defense. A mentally ill person, if cured, would have his commitment time subtracted from his formal sentence. **ACTION DEFERRED,** pending further information from the Council on Mental Health.

A-1056 Muziani—Medication for Pregnant Women*
Requires the attending physician or certified nurse/midwife to obtain an informed consent for any drugs prescribed during pregnancy, labor, and delivery. **ACTIVE OPPOSITION,** physicians have the medical-legal obligation to secure informed consents from all their patients regardless of the condition involved, the sex of the patient, or the therapy recommended. The legislature should not become involved in specific acts of medical judgment and patient information. These must be developed by science, education, and standards of practice. If codification is necessary that is a function of the appropriate regulatory agencies.

A-1073 Hendrickson—Patient Rights
This proposal would affect a statutory bill of rights for patients in general hospitals. It adds nothing to existing common law except detailed procedures. It provides that every person admitted to a general hospital shall have the right: a) to considerate and respectful care; b) to be informed, upon request, of the name of the physician responsible for coordinating his care; c) to obtain from the physician complete current information concerning his diagnosis, treatment, and prognosis in terms he can reasonably be expected to understand. When it is not medically advisable to give this information to the patient, it shall be made available to another person on his behalf; d) to receive from the physician information necessary to give informed consent prior to the start of any procedure or treatment and which, except for those emergency situations not requiring an informed consent, shall include as a minimum the specific procedure or treatment, the medically significant risks involved, and the possible duration of incapacitation, if any. The patient shall be advised of any medically significant alternatives for care or treatment; e) to refuse treatment to the extent permitted by law to be informed of the medical consequences of this action; f) to privacy to the extent consistent with providing adequate medical care to the patient. This shall not preclude discussion of a patient's case or examination of a patient by appropriate health care personnel; g) to privacy and confidentiality of all records pertaining to his treatment, except as otherwise provided by law or third-party payment contract; h) to expect that within its capacity, the hospital will make reasonable response to his request for services; i) to be informed by the physician of any continuing health care requirements which may follow discharge; j) to be informed by the hospital of the necessity of transfer to another facility prior to the transfer and of any alternatives to it whch may exist; k) to be informed, upon request, of other health care and educational institutions that the hospital has authorized to participate in his treatment; l) to be advised if the hospital proposes to engage in or perform human research or experimentation and to refuse to participate in these projects; m) to examine and receive an explanation of his bill regardless of source of payment; n) to be advised of the hospital rules and regulations that apply to his conduct as a patient; and o) to treatment without discrimination as to race, age, religion, sex, national origin, or source of payment. **ACTION DEFERRED,** pending further information from the New Jersey Hospital Association.

A-1096 Schwartz—Nursing Homes/Medicaid
Prohibits nursing homes from leveraging additional payments from Medicaid eligible patients. **DISAPPROVED,** Medicaid payments to hospitals are based on the same rates as those paid by or, on behalf of, all other patients. Medicaid payments to nursing homes are below the rates fairly charged to other patients. As a result of Medicaid patients not paying a fair rate, all other patients are charged more. Medicaid patients and families with assets should make a contribution to a fair rate.

A-1104 Patero—Workmen's Compensation*
Repeals the fellow worker immunity for treating physicians furnished by employers. **DISAPPROVED,** the fellow worker doctrine has been recognized by our State Supreme Court as being a reasonable means for compensating workers injured by the negligence of physicians who are fellow workers. There is no justification to extend professional liability concepts into the workers' compensation system.

A-1116 Patero—Disability Determinations*
Permits licensed psychologists to certify the eligibility of individuals under their care for temporary disability payments. **ACTIVE OPPOSITION,** because psychologists do not have the scientific capability to determine disability or the duration thereof.

A-1130 Paterniti—Nursing Home Care (Blue Cross)
Requires insurers to make available long-term care insurance for senior citizens. There is a 3-day hospital stay as a condition precedent and at least 1,098 days of benefits are mandatory. **APPROVED.**

A-1131 Paterniti—Nursing Home Care
Same as **A-1130,** but applies to medical service corporations. **APPROVED.**

A-1132 Paterniti—Nursing Home Care
Same as **A-1130,** but applies to commercial insurers. **APPROVED.**

A-1133 Paterniti—Nursing Home Care
Same as **A-1130,** but applies to group health insurance. **APPROVED.**

A-1138 Franks
Repeals the Health Department Registry related to drug abusers. **NO ACTION.**

A-1158 Herman—Medicare Assignment*
Requires physicians to advise the SBME as to whether and on what conditions they accept assignments. The Division on Aging is to make that information available to the public. **ACTIVE OPPOSITION,** physician licensure renewals are conducted on a biennial basis. This bill could not be implemented successfully since by the time the information is received and collated it would be "dated." Additionally, most physicians accept assignments based upon the circumstances of each particular patient. This bill would make that impossible and lead to an avoidance of accepting assignment. The physician's policy on assignment readily is available by inquiry of the doctor's office.

A-1165 Herman—Consent for Medical Treatment
Allows a competent adult to appoint an agent who can make medical treatment decisions when that person is not capable of doing so himself. **NO ACTION,** refer to Committee on Biomedical Ethics.

A-1184 Doria—Newborn (S-226)*
Requires hospitals to adopt policies and procedures which ensure newborns receive nourishment and care consistent with accepted medical standards. **ACTION DEFERRED,** pending further information from the New Jersey Chapter, American Academy of Pediatrics.

A-1238 Kavanaugh—Blood and Urine Tests (Motor Vehicle)
Extends implied consent to blood and urine samples and provides immunity to health care pesonnel performing such tests. **APPROVED.**

ACR-49 Hendrickson—Health Care Costs*
Creates a commission to study the rising costs of health care and to evaluate the effectiveness of the Department of Health programs. Four members would be from the general public. **CONDITIONAL APPROVAL,** pending amendment of bill to include physician on commission.

The Reference Committee **recommends** the report be filed.

HOUSE ACTION: Filed.

SUPPLEMENTAL REPORT #3: COUNCIL ON LEGISLATION

(Reference Committee "D")

Asterisk denotes bills of medical significance.

A-496 Doyle—Renal Dialysis
Would require Blue Cross and Blue Shield to provide coverage for home renal dialysis services. Bill withdrawn from files.

A-914 Muhler—Criminally Insane
Provides that murderers who are criminally insane and escape from a psychiatric facility must be placed in the Forensic Psychiatric Hospital and not be returned to the facility from which they escaped. **ACTION DEFERRED,** pending further information from the Council on Mental Health.

A-1285 Kosco—Motor Vehicles*
Extends the "implied consent law" to include blood alcohols. Blood samples may be drawn without the consent of the person if it does not appear serious injury will result or if the blood is being drawn for other medical purposes. **DISAPPROVED,** blood samples and other clinical specimens should not be drawn against the patient's consent and physical resistance.

A-1293 Paterniti—Medical and Scientific Research
Creates a Medical and Scientific Research Authority which is granted the authority to issue bonds. The proceeds will be used to fund research loans. **NO ACTION.**

A-1294 Paterniti—Medical and Scientific Research
Creates a foundation to distribute funds raised by the Bonding Authority. **DISAPPROVED,** this legislation would be difficult to administer and could not produce the funds necessary to fund medical and scientific research.

A-1360 Cuprowski—Sale of Organs
Makes it illegal to participate in commercial organ traffic. **APPROVED.**

A-1372 Otlowski-Hypertension
Expands hypertension screening and control programs being conducted in New Jersey. **DISAPPROVED,** existing law adequately covers this process. The Department of Health is in the best position to present this information to the legislature through appropriate requests under existing law.

A-1421 Schuber—Immunity*
Grants civil and criminal immunity to personnel engaged in speciman collection and analysis. Provides that written reports may be issued and accepted into evidence without a personal appearance. **APPROVED.**

A-1426 Schuber—Administrative Law*
Creates a regulatory agency within the Legislature to promulgate rules and regulations which shall be implemented by the Executive Branch. **APPROVED.**

A-1453 Otlowski—Health Insurance for the Unemployed
Provides health insurance for the recently unemployed. **APPROVED.**

A-1471 Garvin—Informed Consent* (S-1349)
Requires written consent for breast biopsy and/or repair. Physicians that do not secure written consent are subject to discipline by the SBME. **ACTIVE OPPOSITION,** physicians have the medical legal obligation to secure informed consent from all their patients regardless of the condition involved. The Legislators should not become involved in specific acts of medical judgment and patient information. These must be developed by science, education, and standards of practice. If codification is necessary that is a function of the appropriate regulatory agencies.

A-1479 Deverin—X-ray Technicians
Provides for the registration of podiatric, orthopaedic, and urologic x-ray technologists in conformity with standards to be determined by the Radiologic Technology Board of Examiners. **ACTIVE OPPOSITION,** there is no demonstrated evidence that the implementation of this bill will not present an increased risk of radiation exposure to patients. If current standards are maintained the use of limited certificates will not produce more or less expensive technologists. If standards are lowered, the risk to the public is increased.

A-1495 Miller—School Buses*
Provides that school buses must have seat belts and that seat backs shall be padded. **APPROVED.**

A-1541 Karcher—Hypnotechnicians*
Provides for the licensing of hypnotechnicians. Treatments for illness or injury can only be upon written referral of a practitioner of the healing arts. **ACTIVE OPPOSITION,** because this type of technique already is practiced by physicians and other licensed professionals. There is no demonstrated need for separate licensure involving this procedure.

A-1582 Schwartz—Hunger
Creates a 26-member Commission on Hunger to assess the need for services in New Jersey and how those needs might be met. One member of the Commission would be a physician-expert in nutrition. **NO ACTION.**

The Reference Committee **recommends** the report be filed.

HOUSE ACTION: Filed.

Council on Public Relations

Jon Marsicano, M.D., chairman, Iselin
(Reference Committee "D")

The Council on Public Relations maintains the continuity of our coordinated public relations program in reaching the public, the membership, and the media. The Council studied a variety of new projects and instituted those falling within the mandates of the House of Delegates and the Board of Trustees.

CONTINUING PROJECTS

A. Publication and distribution of:
(1) *Membership Newsletter.*
(2) Monthly releases: on "As Good As New"; "Some Would Have You Think DRGs Were Handed Down From The Mountain"; "A Cure For A Kid Killer"; "When In Doubt Ask"; "How Would Your Doctor Compare To Your Great Grandparents' Doctor?"; "Would You Drive A Car Without Insurance?"; A Life Will Be Saved Because Someone Gave Blood"; and "Can You Spot The Person With Hypertension?"

B. Preparation and publication of special news releases and publicity as required from time to time in furtherance of the Society's business interest and activities, including:
(1) The Annual Meeting.
(2) Selected official programs and activities.
(3) Professional Liability—through newspaper articles explaining MSNJ's position on professional liability.

C. The Golden Merit Award ceremony continues to be an important function at which our senior physicians, who have been in practice 50 years, receive special recognition. In 1983, 96 physicians were so recognized, making a total of 1,538 since the awards began in 1957. The recipients and their families receive undivided attention from the state and county leaders prior to the formal awards ceremonies and during the reception that follows.

D. Encouragement of increased voluntary blood donations throughout the year and particularly during vacation time in the summer and over Thanksgiving and Christmas holidays.

E. Encouragement of the continuance or establishment of orientation programs for new members by the component societies.

F. Media Techniques Seminar—The Council on Public Relations conducted a Media Techniques Seminar that included training for participating in interviews on radio, telephone, television, and newspapers. There was a procedural outline offered for processing written requests for medical information and participating in public speaking engagements. A PR manual and a brochure on electronic media interview tips and tactics were offered and discussed. Leaders from the various media shared their expertise with the audience. There was unanimous approval of the program by the physicians who attended. The Board of Trustees approved the Council on Public Relations' recommendation that this seminar be conducted at least once a year.

G. Encouragement of medical television programs of informational value to the public.

H. Placement services in *The Journal.*

I. Coordinate efforts of the Council on Public Relations with the Committee on Drug and Alcohol Abuse for future MSNJ involvement in drug abuse education and prevention.

J. Private Practice—A seminar on marketing strategies for private practice including meeting patient needs, planning for changes in health care delivery systems and hospital/physician relations, patient relations, pricing strategies, choosing location, community involvement, referrals, and managing of time was developed.

NEWSPAPERS

During the past year, we publicized health topics such as the cost of medical care, choosing your own doctor, hypertension, donating blood, professional liability, drunken driving, second medical opinion, safe car seats for children, and new trends in medical care including DRGs.

DIRECT MAIL

Each member received three mailings this year. The members were mailed posters entitled, "You Are What You Eat"; "Give Blood"; and "Some Would Have You Think DRGs Were Handed Down From The Mountain."

TELEVISION

During 1983, public service announcements aired out of New York and Philadelphia reached over three million viewers. This is our most effective method of reaching the population of New Jersey. Cooperation from the 11 television stations running our material continued to be excellent. During 1983, three separate television spots by Doctor Kovacs covered the subjects of rising medical costs, cocaine use, and hearing loss.

SPECIAL PROGRAMMING

A. Preparation of Media Techniques Seminar.

B. Preparation of Women Physicians Membership Drive Promotion.

C. Promotion of Roving Seminar on Substance Abuse.

D. Preparation of Seminar on Marketing Strategies for Private Practice.

DRUG ABUSE

The Council on Public Relations in cooperation with the Committee on Drug and Alcohol Abuse continues to make public service promotions on the hazards of the misuse of drugs.

MEMBERSHIP

A special promotion in cooperation with the American Medical Association was launched to increase the membership of women physicians in MSNJ. Each county society is being given a list of nonmembers from their county to follow up with personal contacts.

The Reference Committee **recommends** that the report be filed.

HOUSE ACTION: Filed.

Board of Trustees' Items

FUTURE PHYSICIAN SUPPLY IN NEW JERSEY

(Reference Committee "D")

As a result of the conclusion reached by the Committee on Medical Education that it was not in a position to produce a thorough and substantive report on the future physician supply in New Jersey, the 1983 House of Delegates adopted the recommendation of Reference Committee "D" that the Medical Society of New Jersey investigates the parameters of future physician supply in New Jersey. The recommendation was referred to staff for research and report.

In July, the Board received a report on projected physician supply and demand by specialty, which had been received from the New Jersey State Department of Higher Education. The report is considered to be a creditable research effort that has been compiled by sound statistical methodology. No reason was found to doubt its validity and, while it is recognized there are subjective elements to it, no better source appears to be available in New Jersey on the topic at this time.

An updated report is expected to be accomplished by the Department of Higher Education following the biennial physician registration. The Board is awaiting future available reports on the topic.

The Reference Committee **recommends** that the report be filed.

HOUSE ACTION: Filed.

Resolution #8

Introduced by: **Board of Trustees**
Subject: **American Association of Medical Assistants-State of New Jersey, Inc.**
Referred to: **Reference Committee "D"**

Whereas, the American Association of Medical Assistants is not only an outstanding professional organization, dedicated to the education and self-improvement of medical assistants, but is the one and only professional organization endorsed and continuously supported through liaison with organized medicine at all levels; and

Whereas, it is recognized that the loyalty, allegiance, and devotion of the members of this organization to their doctor-employers and to organized medicine in the majority of instances goes well beyond the common grounds of the employer-employee relationship; and

Whereas, the American Association of Medical Assistants probably is the most constant, able, and devoted ally of the medical profession; now therefore be it

Resolved, that the Medical Society of New ~~Jersey~~ urge individual physicians to pay the ~~dues~~ of their medical assistants, so ~~that membership~~ in the American Association ~~of~~ Medical Assistants-State of New Jersey, ~~Inc.~~, will continue to grow.

The Reference Committee **recommends** that the following Substitute Resolution for Resolution #8 be adopted:

Resolved, that the Medical Society of New Jersey support the medical assistants in New Jersey so that membership in their organization, the American Association of Medical Assistants-State of New Jersey, Inc., will continue to grow.

HOUSE ACTION: Adopted.

Resolution #14

Introduced by: **L. Arne Skilbred, M.D., Delegate, Essex County**
Subject: **Expand Legislative Service**
Referred to: **Reference Committee "D"**

Whereas, there has been an increase in legislative and regulatory activities, directly involving the medical profession and the delivery of medical care; and

Whereas, many specialty societies and hospital staffs have hired outside help to keep them up to date and informed on legislative and regulatory activities; and

Whereas, the Council on Legislation and the staff of the Medical Society of New Jersey have done a good job with a small staff, but the importance of timely and updated communication requires a larger staff and budget; now therefore be it

Resolved, that the Medical Society of New Jersey allocate increased resources to timely and continuously inform county medical societies, specialty societies, hospital medical staffs, and individual practitioners about upcoming legislative bills and regulatory proposals.

The Reference Committee **recommends** that Resolution #14 be adopted.

HOUSE ACTION: Adopted.

Resolution #15

Introduced by: **Frank J. Primich, M.D., Delegate, Hudson County**
Subject: **Patient Education Program**
Referred to: **Reference Committee "D"**

Whereas, the Constitution of the Medical Society of New Jersey defines its purpose as being, "to promote the betterment of the public health and the science and art of medicine, to enlighten public opinion in regard to the problems of medicine, and to safeguard the rights of the practitioners of medicine"; and

Whereas, the public is being misinformed, physicians' rights are being infringed upon, and the public health is being threatened; and

Whereas, almost every segment of society has focused upon health care providers as the scapegoats for rising health care costs; and

Whereas, the physician image is deteriorating steadily under this unwarranted, but persistent, attack; and

Whereas, current and proposed programs markedly will reduce physicians' incomes; and

Whereas, appeals and lobbying efforts have proved fruitless in obtaining any appreciable legislative or judicial relief; and

Whereas, the last avenue for resolution of the growing problems is to take our case to the public; and

Whereas, current budget allowances preclude any effective campaign; now therefore be it

Resolved, that the Medical Society of New Jersey conduct a "patient education" program, designed to inform the general public regarding the under-publicized factors involved in health care costs and the threat posed to the quality and availability of said care; and be it further

Resolved, that an assessment ~~of $100 be levied upon each~~ member in order to fund this proposal.

The Reference Committee **recommends** that the second **Resolved** be amended to read as follows:

Resolved, that a voluntary assessment of $100 be levied upon each member in order to fund this proposal.

The Reference Committee **recommends** that Resolution #15 be adopted as amended.

HOUSE ACTION: Referred original Resolution and suggested amendment to the Board of Trustees.

Resolution #26

Introduced by: **Union County Medical Society**
Subject: **Advertising on Behalf of HMOs by U.S. Department of Health and Human Services**
Referred to: **Reference Committee "D"**

Whereas, the United States Department of Health and Human Services has mailed to all Medicare recipients a circular bearing an "important message" concerning qualified health maintenance organizations in their area; and

Whereas, this official government message is presented in such a manner as to imply that HMO care is advantageous to the Medicare patient rather than the care rendered them by their own private physician; and

Whereas, such implication causes consternation and creates anxiety for many elderly patients; now therefore be it

Resolved, that the Medical Society of New Jersey protest to the United States Department of Health and Human Services that they cease and desist from using such tactics to promote the growth of health maintenance organizations at the expense of the private practitioner through the use of taxpayer funds to prepare and mail this prejudicial advertising; *and be it further*

Resolved, *that the Medical Society of New Jersey present a Resolution at the next AMA House of Delegates recommending concurrent action by the AMA.*

The Reference Committee **recommends** that Resolution #26 be adopted as amended.

HOUSE ACTION: Adopted as amended (italics indicate amendment).

RESOLUTION #29E

Introduced by: **Fred H. Miller, M.D., Delegate, Atlantic County**
Subject: **New Jersey State Board of Medical Examiners' Pronouncement of Death Regulation**
Referred to: **Reference Committee "D"**

Whereas, the pronouncement of death regulation places the responsibility for pronouncement of death on the attending physician; and

Whereas, a physician covering for a physician thereby is responsible to make the pronouncement of death even though he is not familiar with the patient and therefore pronouncement of death by the covering physician serves no useful purpose other than to relieve the county medical examiner of a duty which used to be one of the responsibilities of the county medical examiner; and

Whereas, this regulation requires physicians to travel unreasonable distances to make the pronouncement of death when in many cases it could be done much more easily by a county medical examiner; and

Whereas, this regulation requires physicians often to travel into dangerous neighborhoods to make the pronouncement of death; and

Whereas, county medical examiners are being unreasonable in the enforcement of this regulation; now therefore be it

Resolved, that the Medical Society of New Jersey take immediate steps to request changes in the regulation to remove the requirement that the patient's attending physician make the pronouncement of death. This service can be provided more efficiently by the emergency room doctor at the nearest hospital or the county medical examiner; and be it further

Resolved, that the Medical Society of New Jersey take steps to change the regulation to state that the county medical examiner may call the attending physician and ask him to make the pronouncement but that it is not a requirement that he do so.

After considerable discussion, in which widely divergent opinions were expressed, the Reference Committee determined that a problem exists between the actual intent of the State Board of Medical Examiners' regulation and the method of county medical examiners in addressing the problem. It was felt that the Board of Trustees, in conversation with the State Board of Medical Examiners and the Chief Medical Examiner, could resolve the problem.

The Reference Committee **recommends** that Resolution #29E be referred to the Board of Trustees.

HOUSE ACTION: Referred to the Board of Trustees.

Reference Committee "E"

Reports:
COUNCIL ON MENTAL HEALTH
COUNCIL ON PUBLIC HEALTH
BOARD OF TRUSTEES' ITEMS
RESOLUTIONS #1, #12, #13, #19

Members:
Christopher T. Reilly, M.D., Chairman, Bergen
Winton H. Johnson, M.D., Sussex
Satwant G. Keswani, M.D., Essex
Lawrence J. Macatee, M.D., Cape May
Frank A. Wolf, M.D., Warren (absent)
Louis G. Bosco, M.D., Alternate Member, Passaic

Council on Mental Health

GEORGE L. TRIEBENBACHER, M.D., CHAIRMAN, BEACH HAVEN
(Reference Committee "E")

Another rewarding year has passed for the Council on Mental Health. Work is continuing on the development of a new mental health booklet.

Title 10—New Jersey Administrative Code. Upon a request from Commissioner George J. Albanese, Department of Human Services, the Council reviewed Title 10 of the New Jersey Administrative Code and forwarded to the Commissioner recommendations for revisions to this code.

Department of Health's Proposed Rules for Psychiatric Inpatient Bed Certificate of Need. The Medical Society of New Jersey, with the agreement of the Council on Mental Health, joined with the New Jersey Psychiatric Association in opposition to the Department of Health's Proposed Rules for Psychiatric Inpatient Bed Certificate of Need (N.J.A.C. 8:43E-2,3,4).

Prescriptions for Controlled Substances—Manner of Issuance of Prescriptions. The Council on Mental Health recommended to the Board of Trustees that the Department of Health be advised that the 30-day limitation on the filling of prescriptions for controlled substances after the date issued (as proposed in an amendment to N.J.A.C. 8:65-7.5) be expanded to include all drugs. This recommendation was approved by the Board of Trustees on January 15, 1984.

State Psychiatric Institutions and Community Mental Health Centers. The Council recommended to the Board of Trustees that a special ad hoc committee be formed, composed of equal members of the Medical Society of New Jersey and the New Jersey Psychiatric Association, to study the present situation involving patient care in and management of state psychiatric institutions and community mental health centers in New Jersey. This recommendation was approved by the Board of Trustees on January 15, 1984, and work is progressing on the organization of such a committee.

I want to thank the members of this Council for their attendance and attention during each meeting as much as for the wealth of their ideas and contributions.

The Reference Committee **recommends** that the report be filed.

HOUSE ACTION: Filed.

Council on Public Health

Edward M. Coe, M.D., chairman, Cranford

(Refcrence Committee "E")

The reorganization meeting of the Council on Public Health was held on December 7, 1983.

A press release was issued as a followup to Substitute Resolution #6—Toxic Waste Disposal, Burlington County. The Council does not endorse any specific company (At-Sea Incineration, Inc.) as some members believe was implied in the press release.

The Council approved the Committee on Cancer Control's recommendation that physicians in the state who are involved in tumor work be identified and urged to join the Oncology Society of New Jersey. Upon a request from the Board of Trustees prior to approval of the recommendation, the Committee on Cancer Control will report on the requirements for membership in the Oncology Society of New Jersey.

The Committee on Cancer Control and the Council on Public Health recommended that MSNJ establish a Cancer Control Coordinating Council, to avoid duplication of effort and to develop a cancer plan for New Jersey to coordinate activities throughout the state. This recommendation was approved by the Board of Trustees at its meeting on January 15, 1984.

The Reference Committee **recommends** that the report be filed.

HOUSE ACTION: Filed.

Supplemental Report #1: Council on Public Health

Edward M. Coe, M.D., chairman, Cranford

(Reference Committee "E")

The following items contained in the April 4, 1984, report of the Committee on Conservation of Vision, of the Council on Public Health, were presented to and approved by the Board of Trustees at its meeting on April 15, 1984.

WORKER'S EYE CARE PROJECT

A Worker's Eye Care Project has been launched by the American Academy of Ophthalmology with the cooperation of the National Society to Prevent Blindness, which is a new public service project for the nation's corporate employees.

The project is designed to encourage effective eye care for corporate employees by having ophthalmologists donate their time and medical expertise to assist corporations in establishing and maintaining high-quality eye care programs. Corporate medical personnel will be taught to provide vision screening, to detect the warning signs of eye problems, and to refer workers to appropriate care.

New Jersey has been chosen as one of three states for the demonstration phase of the program which has been endorsed by the National Society to Prevent Blindness-New Jersey, the New Jersey Academy of Ophthalmology, the New Jersey State Commission for the Blind and Visually Impaired, and the Lions Club of New Jersey.

The Committee recommended that the Medical Society of New Jersey endorse and support the Worker's Eye Care Project.

1984 EYE HEALTH SCREENING PROGRAM

The Committee on Conservation of Vision recommended the week of September 17, 1984, as the date for the 1984 Eye Health Screening Program.

The Reference Committee **recommends** that the report be filed.

HOUSE ACTION: Filed.

Board of Trustees' Items

PRESCRIBING, ADMINISTERING, OR DISPENSING AMYGDALIN (LAETRILE)

(Reference Committee "E")

In December, the Board of Trustees reviewed a proposed amendment to laetrile regulations and a report from the Committee on Cancer Control that indicates laetrile is of no true medical value. The Medical Society of New Jersey is petitioning the New Jersey Legislature and the Department of Health to have the drug removed from use in New Jersey. We are hopeful the State Board of Medical Examiners will join with us in this request.

The Reference Committee **recommends** that the report be filed.

HOUSE ACTION: Filed.

THIRD TRIMESTER ABORTIONS

(Reference Committee "E")

The 1983 House of Delegates considered Resolution #17 on Third Trimester Abortions (Burlington County Medical Society), and directed that it be referred to the Committee on Maternal and Child Care for discussion and report back to the 1984 House of Delegates.

The Committee felt that by saying the Society "no longer endorses" third trimester abortions, it is implied that the Society endorsed them before this resolution was submitted to the House of Delegates. It was pointed out that, according to all available records, the Medical Society of New Jersey never has taken a stand of endorsement or otherwise on the issue of third trimester abortions as implied in the resolution. Third trimester abortions are not compatible with the accepted standard of medical care. Also, given the status of the law, it is not clear what action if any by the Medical Society of New Jersey would produce meaningful results. It was felt that the resolution as submitted is inaccurate in its definition of the issue.

The Board of Trustees concurred with the statement developed by the Committee on Maternal and Child Care. It was suggested to the Burlington County Medical Society that if it wishes to pursue this matter, further language should be developed which is consistent with the points expressed above.

The Reference Committee **recommends** that the report be filed.

HOUSE ACTION: Filed.

RESOLUTION #1

Introduced by: **Board of Trustees**
Subject: **Driving Under the Influence of Alcohol and Other Drugs**
Referred to: **Reference Committee "E"**

Resolved, that the Medical Society of New Jersey support legal means to remove intoxicated drivers (both alcohol and drug abusers) from the road because they are a public health hazard; and be it further

Resolved, that the Medical Society of New Jersey alert physicians treating injury cases that substance abuse (alcohol and other drugs) may be the underlying cause in auto accident injuries; and be it further

Resolved, that the Medical Society of New Jersey remind physicians that substance abuse is a treatable illness and that it is their duty to refer such individuals to appropriate treatment programs; and be it further

Resolved, that the Medical Society of New Jersey urge school physicians to develop educational programs in cooperation with their local board of education that will promote understanding of the conflict between intoxication and driving; and be it further

Resolved, that this resolution be forwarded to the AMA for its approval and national implementation.

The Reference Committee **recommends** that the third **Resolved** be amended to read:

Resolved, that the Medical Society of New Jersey remind physicians that substance abuse is a treatable illness and that it is appropriate to refer such individuals to treatment programs; and be it further

The Reference Committee **recommends** that Resolution #1 be adopted as amended.

HOUSE ACTION: Adopted as amended.

RESOLUTION #12

Introduced by: **Essex County Medical Society**
Subject: **Water Pollution**
Referred to: **Reference Committee "E"**

Whereas, according to reports in the press, millions of gallons of sewage per day from a new Manhattan waterfront community will be sent to a treatment plant unable to handle the extra load, resulting in increased pollution of New York Harbor and further contaminating the water drifting to the New Jersey shore; and

Whereas, three separate, large Manhattan projects (new Convention Center, the Battery Park City, and the South Street redevelopment area) currently are being developed without provisions for proper sewage disposal, and are, or will be, dumping raw sewage, pumped directly into the Hudson and East Rivers; and

Whereas, the world's largest convention center on the Hudson River at 37th Street will pump sewage from this structure directly into the river and flush wastes from as many as 80,000 convention visitors a day will be added to the 150 million gallons of raw sewage already gushing daily into the Hudson River from most of the West Side of Manhattan, which has no treatment plant in operation; and

Whereas, this situation will worsen as these projects are further built and utilized; and

Whereas, current sewage treatment centers will not be able to handle this extra load until 1991; and

Whereas, these raw wastes drift on tidal currents to flow along or against Monmouth and Ocean County beaches, resulting in conditions which are hazardous to the health and welfare of our citizens; and

Whereas, such raw sewage already has disrupted and curtailed our clamming, oystering, lobstering, and fishing industries; now therefore be it

Resolved, that the Medical Society of New Jersey write to the governors of both New Jersey and New York, asking for mutual cooperation on this important matter, and requesting a cooperative effort in halting further pollution to an already polluted coastal area; and be it further

Resolved, that the Medical Society of New Jersey send copies of this resolution to designated officials of the Federal Environmental Protection Agency, the National Oceanic and Atmospheric Administration, and the New Jersey Department of Environmental Protection, as well as other concerned government officials to put an end to this pernicious practice which is a gross abuse of the environment; and be it further

Resolved, that a moratorium be sought on all new construction in the harbor area until adequate sewage disposal facilities are operational.

The Reference Committee **recommends** that Resolution #12 be adopted.

HOUSE ACTION: Adopted.

RESOLUTION #13

Introduced by: **Essex County Medical Society**
Subject: **Medical Emergency Protocol**
Referred to: **Reference Committee "E"**

Whereas, physicians sometimes report that they start to stabilize an emergency patient and evaluate priorities, then the aid squad or emergency personnel sometimes take over and override the doctor's diagnosis or treatment; and

Whereas, the physician still may have a legal or moral responsibility in the case when paramedics reject physician assistance and the patient is transported to a hospital; and

Whereas, there is no statewide or areawide protocol for handling an emergency; now therefore be it

Resolved, that the Medical Society of New Jersey establish a committee to draft proper rules and protocol concerning the handling of medical emergencies to improve such situations on behalf of the patient; and be it further

Resolved, that the Medical Society of New Jersey disseminate such protocol and standards to *medical students, residents, and* relevant departments of government and private services who handle emergencies in this state.

The discussion at the Reference Committee revolved around the roles of the physicians, the ambulances, and the Mobile Intensive Care Units (MICU). Due to conflicting opinions regarding the existence of a current protocol for MICU concerning the handling of medical emergencies, the Reference Committee felt that more study is needed before Resolution #13 properly can be considered.

The Reference Committee **recommends** that Resolution #13 be referred to the Board of Trustees for further study.

HOUSE ACTION: Adopted as amended (italics indicate amendments).

RESOLUTION #19

Introduced by: **Burlington County Medical Society**
Subject: **Mammography**
Referred to: **Reference Committee "E"**

Whereas, breast cancer will afflict 1 of every 11 women during their lifetime, causing 35,000 deaths annually; and

Whereas, over 30 years of efforts to improve survival in breast cancer through improvements in surgery, chemotherapy, and radiation therapy have met with only modest success; and

Whereas, the best hope of attaining better survival rates in this disease lies with early detection; and

Whereas, the only method for detecting breast cancer before it is palpable or metastatic is mammography; and

Whereas, mammography carries a high sensitivity (circa 90 percent) for detection of minimal, occult, and early breast cancer lesions; and

Whereas, survival in breast cancer detected early is on the order of 95 percent; and

Whereas, guidelines put forth by the American College of Radiology have been endorsed either wholly or in similar form by the American Cancer Society, the American College of Surgeons, the American College of Obstetricians and Gynecologists, and the National Institute of Health; now therefore be it

Resolved, that the Medical Society of New Jersey adopt and endorse the guidelines advocated by the American College of Radiology and others as follows: (a) Women between the ages of 35 and 40 years of age should have a baseline mammogram. (b) Between ages 40 and 50, frequency of mammography should be every two years. Clinical or risk factors evaluated by the patient's physician may alter this frequency. (c) After age 50, yearly mammography is recommended; and be it further

Resolved, that mammograms following from these recommendations should be made with equipment dedicated to this procedure.

The Reference Committee **recommends** that the following Substitute Resolution for Resolution #19 be adopted:

Resolved, that the Medical Society of New Jersey endorse the guidelines advocated by the American College of Radiology regarding mammography screening; and be it further

Resolved, that mammograms following from this recommendation should be made with equipment designed for this procedure.

HOUSE ACTION: No action taken on Resolution #19.

Reference Committee on Constitution and Bylaws

Report:

COMMITTEE ON REVISION OF CONSTITUTION AND BYLAWS RESOLUTIONS #2, #4, #10

Members:
Joseph A. Riggs, M.D., Chairman, Camden
Joseph P. Cillo, M.D., Union
Matis A. Fermaglich, M.D., Bergen
Thomas E. Mattingly, Jr., M.D., Burlington
Joseph N. Micale, M.D., Hudson
John E. Durst, M.D., Alternate Member, Monmouth

Committee on Revision of Constitution and Bylaws

Carl A. Restivo, sr., m.d., chairman, jersey city
(Reference Committee on Constitution and Bylaws)

PROPOSED AMENDMENTS TO THE BYLAWS

1. Chapter VI—Other Delegates and Representatives

The current Bylaws provide for the election of individuals to serve as delegates and alternates to other state medical societies. Over the years, delegates have been elected to serve as the Medical Society of New Jersey's representatives to the states of Connecticut and New York.

The Committee on Long-Range Planning and Development is of the opinion that since the President of the Society is invited to meetings of these state societies, a separate delegate adds nothing to the Medical Society of New Jersey's presence. It was felt that the individual representing the Society should be knowledgeable and able to articulate the Society's position on current issues. Representation of the Society is a function of the President and presidential officers.

The Board of Trustees adopted a recommendation, submitted by the Committee on Long-Range Planning and Development, to discontinue the practice of electing delegates and alternate delegates to other states, with the provision that the selection of the individual to represent the Society at the meetings should be left to the discretion of the President.

Bylaws		
Chapter VI—Other Delegates and Representatives	Chapter VI—AMA Delegates and Other Representatives	
Current	*Proposed*	
Delegates and alternate delegates to other medical organizations shall be elected in accordance with the provisions of these Bylaws.	Delete	
(a) American Medical Association The terms of office of delegates and alternate delegates shall begin on January 1 of the year following their election, and shall continue for two (2) years, ending on the second December 31 thereafter. In the absence of any delegate, any alternate delegate shall be eligible to serve. No member shall serve more than six (6), two-year terms as an AMA delegate or alternate, or any combination thereof.	(a) American Medical Association Same	
(b) Other Medical Organizations When representation has been recommended by the Board of Trustees and approved by the House of Delegates, such delegates and alternate delegates shall be elected for terms of one (1) year.	(b) All Other Organizations Official representatives from this Society shall be appointed by the Board of Trustees or by the President. Their functions and terms shall be set forth in their notice of appointment.	
(c) Representatives Official representatives from this Society to other organizations shall be appointed by the Board of Trustees or by the President with the approval of	Delete	

the Board of Trustees. Their functions and terms shall not exceed those set forth in their official notice of appointment.

The Committee on Revision of Constitution and Bylaws finds such a change desirable and recommends that the proposal be adopted.

The Reference Committee **recommends** the proposal be adopted.

HOUSE ACTION: Adopted.

2. Chapter III—Board of Trustees

Under the current Bylaws, the President appoints, with the advice and consent of the Board of Trustees, the individual who will serve as its Chairman for the year.

The Committee on Long-Range Planning and Development questioned whether the dual leadership structure under which the Society now functions is conducive to the efficient operation of the organization.

It was the concensus of the Committee on Long-Range Planning and Development and the Board of Trustees, that the President should act as the chief executive officer of the Society and chair all meetings of the Board of Trustees.

Bylaws

Chapter III—Board of Trustees	Chapter III—Board of Trustees
Current	*Proposed*
(a) Composition and Apportionment	(a) Composition and Apportionment
The Board of Trustees shall be the executive body and shall be composed of the Immediate Past-President, President, President-Elect, two (2) Vice-Presidents, Secretary, and Treasurer (by virtue of their offices), and elected Trustees — by at least two (2) from each judicial district for a membership up to one thousand (1,000); each judicial district shall be entitled to one (1) additional Trustee for each additional one thousand (1,000) members, or major fraction thereof, computed as of December 31.	Same
(b) Organization	(b) Organization
At the first meeting of the Board of Trustees following each annual meeting of the House of Delegates, the President shall appoint with the advice and consent of the Board of Trustees, a Chairman of the Board. The Chairman shall name the membership of all committees of the Board of Trustees. Meetings shall be called by the Chairman, but any four (4) Trustees may—in writing and for stated reasons — require the Chairman to call a meeting. Notices of meetings shall be mailed at least seven (7) days in advance of the meeting date. Nine (9) Trustees shall constitute a quorum. The Secretary of the Society shall serve as Secretary of the Board.	The President shall act as Chairman of the Board of Trustees. The President shall name the membership of all committees of the Board of Trustees. Meetings shall be called by the President, but any four (4) Trustees may—in writing and for stated reason — require the President to call a meeting. Notices of meetings shall be mailed at least seven (7) days in advance of the meeting date. Nine (9) Trustees shall constitute a quorum. The Secretary of the Society shall serve as Secretary of the Board.
(c) Executive Committee	(c) Executive Committee
The President, President-Elect, First and Second Vice-Presidents, Immediate Past-President, and the Chairman of the Board of Trustees shall compose the Executive Committee. It shall act on emergency measures when time does not permit a meeting of the Board of Trustees. Any action thus taken shall be subject to formal action of the Board of Trustees at its next meeting.	The President, President-Elect, First and Second Vice-Presidents, and the Immediate Past-President shall compose the Executive Committee. It shall act on emergency measures when time does not permit a meeting of the Board of Trustees. Any action thus taken shall be subject to formal action of the Board of Trustees at its next meeting.
(d) Powers	(d) Powers
The Board of Trustees shall exercise general supervision over the affairs of this Society, shall have authority to act between annual meetings, and shall perform the following functions: Make recommendations to the House of Delegates; Assign business to and advise in the deliberations of committees; Supervise the work of the Committee on Publication and appoint an editor and such other assistants as the publication of *The Journal* may require; Make suitable provision for the efficient conduct of the business of this Society; Engage counsel as necessary	Same

and negotiate fees for services to be rendered;

Determine all salaries;

Pass upon all recommendations for expenditures in excess of budgetary appropriations;

Bond the Treasurer, the Chairman of the Committee on Finance and Budget, and other necessary personnel;

Fill vacancies in all offices and elected committees unless otherwise provided in the Constitution and Bylaws.

(e) Property	(e) Property
The Board of Trustees shall have sole authority to lease, sell, or otherwise convey or dispose of any or all property of this Society, both personal and real.	Same
(f) Committee on Finance and Budget	(f) Committee on Finance and Budget
Three (3) Trustees shall serve on the Committee on Finance and Budget.	Same
(g) Annual Report	(g) Annual Report
The Board of Trustees shall render annually to the House of Delegates a summary of its activities.	Same

Since the office of Chairman is being abolished, Chapter IX—Administrative Councils and Committees, Section 3-1, Council on Legislation must be amended by deleting the last sentence which refers to the Chairman of the Board as an ex-officio member.

Chapter IX—Administrative Councils and Committees

Section 3—Administrative Councils, Standing Committees and Special Committees

1. Council on Legislation

Current	*Proposed*
The Council on Legislation shall consist of 12 members, 6 of whom shall be elected by the House of Delegates, and 6 appointed by the President. There shall be at least 1 elected and 1 appointed member from each judicial district. The Chairman of the Board of Trustees shall be an ex-officio member of the Council on Legislation.	The Council on Legislation shall consist of 12 members, 6 of whom shall be elected by the House of Delegates, and 6 appointed by the President. There shall be at least 1 elected and 1 appointed member from each judicial district.

The Committee on Revision of Constitution and Bylaws recommends that the proposal be adopted.

Although there was considerable discussion against adoption of this change on the Bylaws, it is the opinion of the Reference Committee that the President of the Society, as an elected official, should have the opportunity to make policy for that year and be responsible to conduct the meetings of the Board of Trustees. Further, the Reference Committee concurs with the reasoning of the Committee on Long-Range Planning and Development, the Committee on Revision of Constitution and Bylaws, and the Board of Trustees, all of which support this proposal.

The Reference Committee **recommends** that the proposed change to the Bylaws be adopted.

HOUSE ACTION: Adopted.

3. Chapter II—Meetings, Section I—Delegates

(g) Hospital Medical Staff Section

In 1982, the American Medical Association approved the establishment of a hospital medical staff section within its House of Delegates.

The Committee discussed the AMA action and recognized the need for representation of medical staffs in the formulation and implementation of policies in the area of physician-hospital relationships. The Committee believes it is both timely and appropriate for organized medicine to establish a representative structure to focus on these needs.

Bylaws

Chapter II—Meetings	Chapter II—Meetings
Section 1—Delegates	Section 1—Delegates
Current	*Proposed*
None	(g) Hospital Medical Staff Section The Hospital Medical Staff Section shall be entitled to one delegate and one alternate in the House of Delegates.

The Committee on Revision of Constitution and Bylaws recommends that the proposal be adopted.

The Reference Committee recognized that the establishment of a Hospital Medical Staff Section should entitle that section to one delegate and one alternate delegate in the House of Delegates, and agreed with the Committee on Revision of Constitution and Bylaws that Chapter II, Section 1 be so amended.

The Reference Committee **recommends** that the proposal be adopted.

HOUSE ACTION: Adopted.

Supplemental Report #2: Board of Trustees

Douglas M. Costabile, M.D., Chairman, Murray Hill

HOSPITAL MEDICAL STAFF SECTION

(Reference Committee on Constitution and Bylaws)

The American Medical Association House of Delegates adopted a resolution in 1983 encouraging every state medical association to establish a statewide hospital medical staff section.

The Medical Society of New Jersey and its component societies have worked closely with hospital medical staffs, and have been involved actively with their organizational structure in New Jersey. It has become apparent to the Board of Trustees that the involvement of hospital medical staffs within the structure of organized medicine is essential to the well-being of the Medical Society of New Jersey and the AMA, and ultimately to the preservation of the professionalism of practicing physicians.

The Medical Society of New Jersey and the medical staffs will benefit by the development of a representative structure which would:

1. Provide a system to solve problems and to avoid polarization of medical staffs and other groups of physicians.
2. Provide a vehicle to identify the implications of future trends on the role of physicians individually and as members of medical staffs.
3. Acquaint medical staff leadership with policy structure in organized medicine.
4. Provide appropriate support to local and state medical staff representatives.
5. Develop and maintain information on issues of common concern to medical staffs and distribute data on successful approaches.
6. Provide an easy contact point for medical staff leaders with AMA and MSNJ resources.

The Hospital Medical Staff Section of the Medical Society of New Jersey should:

1. Represent the hospital medical staff unit.
2. Provide a built-in incentive for increased regular membership in organized medicine.
3. Be adaptable to state and local medical societies if they choose to do so.
4. Provide for election or selection of representatives by the medical staff unit.
5. Have policy access to the MSNJ House of Delegates.
6. Provide for representation on an ongoing basis.

The Board of Trustees believes it is both timely and appropriate for the Society to consider the creation of a special section.

Recommendation: That the House of Delegates approve the establishment of a Hospital Medical Staff Section.

Recognizing the wisdom of the action of the AMA's House of Delegates in adopting a resolution in 1983 encouraging every state medical association to establish a statewide hospital medical staff section, the Reference Committee endorses the establishment of a hospital medical staff section in the Medical Society of New Jersey.

The Reference Committee **recommends** that the recommendation of the Board of Trustees be adopted.

HOUSE ACTION: Adopted.

RESOLUTION #2

Introduced by: **Union County Medical Society**
Subject: **Composition of AMA Delegation**
Referred to: **Reference Committee on Constitution and Bylaws**

Whereas, at the June 1983 AMA House of Delegates, a resolution was adopted expressing the desire that presidents of all state medical societies should be delegates or alternates to the AMA House of Delegates; and

Whereas, it is appropriate that those holding a position of responsibility at the state level be able to impact effectively on AMA positions; now therefore be it

Resolved, that Chapter VI of the Bylaws of the Medical Society of New Jersey be changed to require that one position as alternate delegate to the AMA be reserved for the president of the state medical society to be passed on to the next president in turn on an annual basis; and be it further

Resolved, that if the president is a duly elected delegate or alternate delegate at the time of his ascension to the presidency, the reserved position should be given to the president-elect; if he/she already is a delegate or alternate, then to the immediate past-president.

The Reference Committee **recommends** that Resolution #2 be adopted.

HOUSE ACTION: Resolution #2 was withdrawn on the floor of the House of Delegates.

RESOLUTION #4

Introduced by: **Union County Medical Society**
Subject: **Representation of Hospital Staffs in MSNJ House of Delegates**
Referred to: **Reference Committee on Constitution and Bylaws**

Whereas, the American Medical Association has developed a Hospital Medical Staff Section for its House of Delegates; now therefore be it

Resolved, that the Medical Society of New Jersey develop a Hospital Medical Staff Section to be characterized as a specialty society for the purpose of delegation.

In view of the actions taken on previous Medical Staff Section proposals creating a Hospital Medical Staff Section and providing for appointment of a delegate and an alternate delegate, Resolution #4 is redundant.

The Reference Committee **recommends** that Resolution #4 be rejected.

HOUSE ACTION: Rejected.

RESOLUTION #10

Introduced by: **Robert J. Weierman, M.D., Delegate, Essex County**
Subject: **Establishment of A Medical Society of New Jersey Hospital Medical Staff Section**
Referred to: **Reference Committee on Constitution and Bylaws**

Whereas, the AMA has established a Hospital Medical Staff Section with representation in the AMA House of Delegates; and

Whereas, this section has been actively representing medical staffs at the annual and interim sessions of the AMA in 1983; and

Whereas, the AMA recommends that all state and county medical societies establish such a section or committee; now therefore be it

Resolved, that the Medical Society of New Jersey establish a Hospital Medical Staff Section with appropriate representation in the House of Delegates; and be it further

Resolved, that the Medical Society of New Jersey encourage all county medical societies to activate a liaison section or committee, composed of representatives from local hospital medical staffs.

In view of the actions taken on previous Medical Staff Section proposals creating a Hospital Medical Staff Section and providing for the appointment of a delegate and an alternate delegate, Resolution #10 is redundant.

The Reference Committee **recommends** that Resolution #10 be rejected.

HOUSE ACTION: Rejected.

1983 House Of Delegates Election

Office	Term	Nominee and County
President-Elect	1 year	Ralph J. Fioretti, M.D., Bergen
First Vice-President	1 year	Edward A. Schauer, M.D., Monmouth
Second Vice-President	1 year	Harry M. Carnes, M.D., Camden
Trustees:		
1st District	3 years	Douglas M. Costabile, M.D., Union
1st District	3 years	Bernard Robins, M.D., Essex
2nd District	3 years	Carl Restivo, Jr., M.D., Hudson
2nd District	3 years	Gerald H. Rozan, M.D., Passaic
3rd District	3 years	Michael M. Heeg, M.D., Mercer
3rd District	3 years	Palma E. Formica, M.D., Middlesex
4th District	3 years	John P. Kengeter, M.D., Ocean
4th District	1 year	Louis L. Keeler, M.D., Camden (for Dr. Carnes)*
Judicial Councilors:		
3rd District	1 year	Louis G. Fares, M.D., Mercer
1st District	3 years	Edward M. Coe, M.D., Union
4th District	3 years	Frederick W. Durham, Camden
AMA Delegates:		
	2 years	Alfred A. Alessi, M.D., Bergen
	2 years	Frederick W. Durham, M.D., Camden
	2 years	Palma E. Formica, M.D., Middlesex
	2 years	Karl T. Franzoni, M.D., Mercer
	2 years	John S. Madara, M.D., Salem
	2 years	Henry J. Mineur, M.D., Union
AMA Alternate Delegates:		
	½ year**	Joseph A. Riggs, M.D., Camden
	2 years	Joseph A. Riggs, M.D., Camden
	2 years	Augustus L. Baker, Jr., M.D., Morris
	2 years	Charles S. Krueger, M.D., Burlington
	2 years	Carl A. Restivo, Sr., M.D., Hudson
	2 years	Robert H. Stackpole, M.D., Union
Delegates and Alternate Delegates to other states:		
New York:		
Delegate	1 year	F. Sterling Brown, M.D., Atlantic
Alternate	1 year	John J. Pastore, M.D., Cumberland
Connecticut:		
Delegate	1 year	Frank R. Romano, Sr., M.D., Union
Alternate	1 year	Gastone A. Milano, M.D., Atlantic

*Unexpired term of Daniel J. O'Regan, M.D., deceased.

Administrative Councils:		
Legislation:		
5th District	3 years	L. Willis Allen, M.D., Cumberland
6th Member	3 years	Howard H. Lehr, M.D., Union
Medical Services:		
5th District	3 years	John J. Pastore, M.D., Cumberland
6th Member	3 years	Frank A. Wolf, M.D., Warren
Mental Health:		
3rd District	3 years	Joseph J. Kline, M.D., Mercer
6th Member	3 years	William R. Nadel, M.D., Union
Public Health:		
5th District	3 years	Narasimhaloo Venugopal, M.D., Cumberland
6th Member	3 years	Glenn P. Lambert, M.D., Hunterdon
Public Relations:		
2nd District	3 years	Joseph W. Bitsack, M.D., Bergen
5th District	3 years	John J. Pastore, M.D., Cumberland
Standing Committees:		
Annual Meeting	3 years	Thomas J. Connolly, Jr., M.D., Hudson
Auxiliary Advisory	3 years	J. James Pegues, M.D., Burlington
Finance and Budget	3 years	Matis A. Fermaglich, M.D., Bergen
Medical Defense & Insurance	3 years	E. Arthur Kratzman, M.D., Union
Medical Education	3 years	Edwin W. Messcy, M.D., Burlington
Publication	3 years	Dirck L. Brendlinger, M.D., Burlington

*Doctor Carnes was elected Second Vice-President
**Unexpired term of Daniel J. O'Regan, M.D., deceased.

ATTENDANCE

County	Delegates	Members	Total
Atlantic	7	19	26
Bergen	30	23	53
Burlington	12	9	21
Camden	24	26	50
Cape May	3	—	3
Cumberland	5	5	10
Essex	58	61	119
Gloucester	4	7	11
Hudson	21	15	36
Hunterdon	—	—	—
Mercer	20	16	36
Middlesex	24	20	44
Monmouth	21	28	49
Morris	19	11	30
Ocean	12	13	25
Passaic	23	15	38
Salem	3	3	6
Somerset	6	4	10
Sussex	3	4	7
Union	35	21	56
Warren	3	—	3
Fellows and Officers	17	—	17
	350	300	650
Delegates Speciality Societies	4		4
Delegate MSNJ Student Association	1		1
	355		
Physician Guests			51
Physicians Exhibitors			1
Total Physician Registration			707
Auxiliary			180
Visitors			219
Exhibitors			61
Total Registration			1,167

Three-Year Comparative Registration Figures

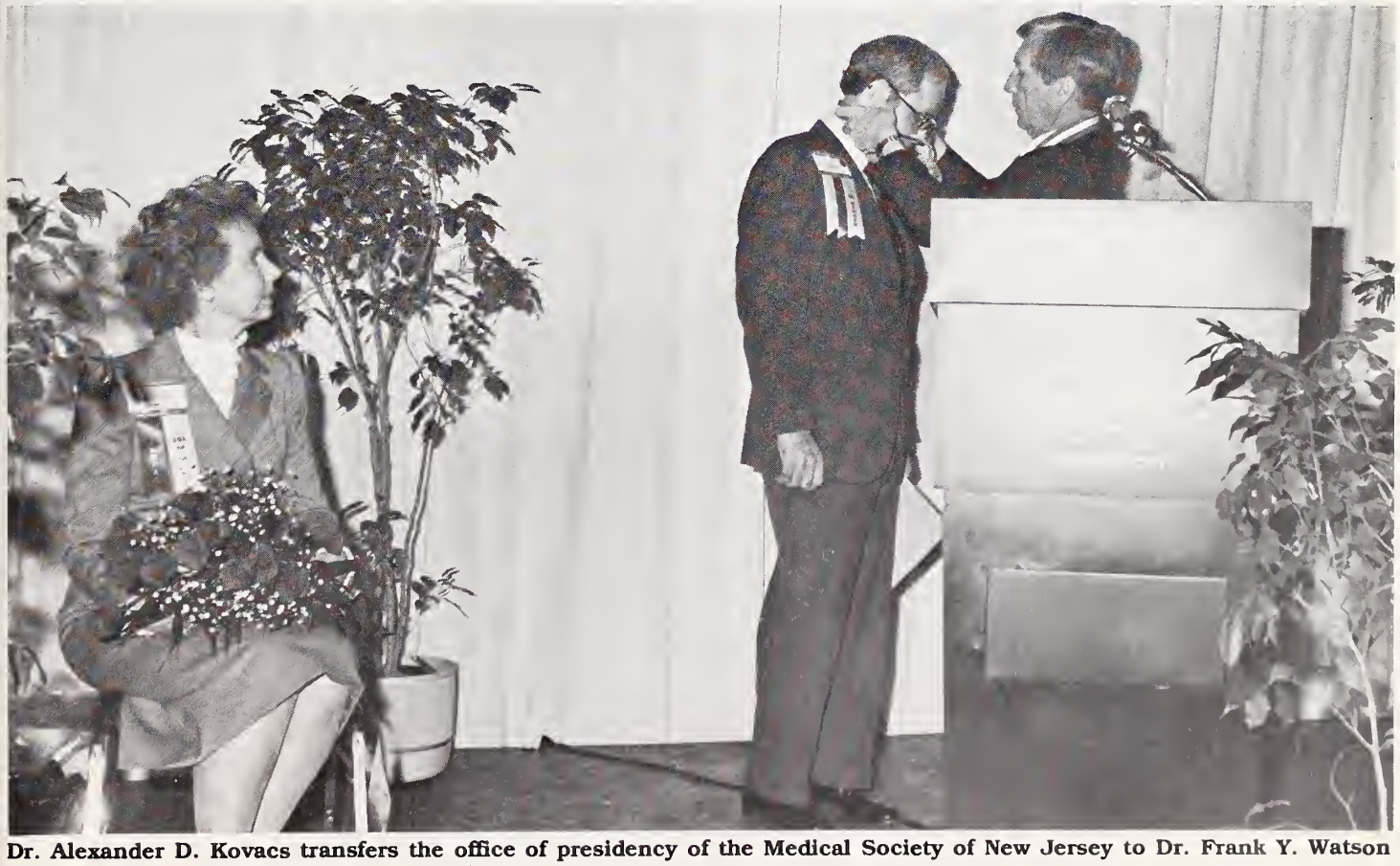
Year	Physicians	Others	Total
1984	707	460	1,167
1983	814	454	1,268
1982	923	631	1,554

THE ANNUAL MEETING

The 218th Annual Meeting of the Medical Society of New Jersey was held at Resorts International Hotel and Casino, Atlantic City, May 3 to May 6, 1984. The following pictures are just a sample of what went on:



Outgoing President, Alexander D. Kovacs, M.D., receives Fellow's Key from the Immediate Past-President, Howard D. Slobodien, M.D.



Dr. Alexander D. Kovacs transfers the office of presidency of the Medical Society of New Jersey to Dr. Frank Y. Watson as his wife, Dr. Carolyn W. Watson, looks on.



At the Inaugural Reception, President Frank Y. Watson and his wife, Dr. Carolyn W. Watson, Mrs. Watson's brother, William M. Wolfe, with Speaker of the House, Dr. Henry J. Mineur and his wife, Mary Lou.



A view of the officers' platform at MSNJ's 218th Annual Meeting as Dr. Alexander D. Kovacs addresses the House of Delegates



Dr. L. Arne Skilbred and his wife. Dr. Skilbred introduced Dr. Watson to the House of Delegates when he delivered his inaugural address.



The 1984-85 Medical Society of New Jersey Board of Trustees. The bottom row (left to right): Drs. Fullerton; Carnes; Schauer; Fioretti; Watson; Kovacs; Bernstein; Hirsch; Keeler. The top row (left to right): Drs. Heeg; Robins; Pastore; Costabile; Rozan; Kengeter; Formica; Cherashore; Restivo, Jr.; Gingerelli; Morrison.



Mrs. Gale Wayman, President of MSNJ's Auxiliary, AMA Trustee Dr. James S. Todd, Senator Bill Bradley, guest speaker, and Dr. William E. Ryan, chairman of JEMPAC, at the JEMPAC Political Forum, on May 4, 1984.



Mrs. B. Ralph Wayman, Jr., President of MSNJ's Auxiliary, Mrs. John Bates, AMA Auxiliary President, and State President-Elect, Mrs. William Gellman.

119879

3 1378 00481 0837